

health, Welfare public service  
300 1-56  
All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
Hu bert M. Parker

FILED JUN 28 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

57021339  
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2679

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Mary's Hosp.</b>			Length of stay in lb <b>13 yrs</b>		d. STREET ADDRESS <b>3518 Central</b> (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>MARIE</b> Middle <b>T.</b> Last <b>SCHOENE</b>				4. DATE OF DEATH Month <b>6</b> Day <b>7</b> Year <b>57</b>					
5. SEX <b>Fe</b>		6. COLOR OR RACE <b>Wh</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-24-1870</b>		9. AGE (In years last birthday) <b>87</b> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (City and state or country) <b>Germany 4</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>No Record</b>				14. MOTHER'S MAIDEN NAME <b>No Record</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No xx</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Helen Schoene, 3518 Central, K.C. Mo.</b> Address _____				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Carcinomatous</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: <b>Carcinoma of rt breast</b> DUE TO (b) <b>remained 5 years ago</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>arteriosclerotic heart disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>170x</b>		
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <b>6-21-54</b> to <b>6-7-57</b> and last saw <sup>her</sup> <del>him</del> alive on <b>6-7-57</b> . Death occurred at <b>10:35 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Type or print) <b>Hu bert M. Parker M.D.</b>					22b. ADDRESS <b>928 Ogyle</b>			22c. DATE SIGNED <b>6-7-57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>6-8-57</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Mem. Park Cem.</b>		23d. LOCATION (City, town, or county) <b>St. Louis,</b> (State) <b>Mo.</b>			
24. FUNERAL DIRECTOR <b>Wagner Funeral Home, K C Mo.</b> ADDRESS _____				25. DATE RECD. BY LOCAL REG. <b>6-7-57</b>		26. REGISTRAR'S SIGNATURE <b>Neva Minshall</b>			

JUN 28 1951

V1-2-3-33

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ..... Student Embalmer No. .... working under my personal supervision.

Student ..... Signature of Student Embalmer

Signed *Abner R. Hainschile*

Licensed Embalmer No. *41*

P. O. Address *R. E.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.