. Health,
& Welfare
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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 36121

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4707

1. PLACE OF DEATH a. COUNTY Jackson	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Kansas City — Inside Limits Yes [X] No [ ]	c. CITY OR TOWN Kansas City — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Lukes Hospital — Length of stay in 1b 18 months	d. STREET ADDRESS (If outside, give location) 15 West 61st Terr. — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First CHARLES	Middle MICHAEL	Last SCHAFER	4. DATE OF DEATH Month OCTOBER Day 8, Year 1957
5. SEX Male	6. COLOR OR RACE white	7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]	8. DATE OF BIRTH Nov. 6, 1954
9. AGE (In years last birthday) 2 yrs.	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) Child	10b. KIND OF BUSINESS OR INDUSTRY -------	11. BIRTHPLACE (City and state or country) Salisbury, Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Charles M. Schafer	13b. MOTHER'S MAIDEN NAME Beatrice Ann McManus	14. NAME OF HUSBAND OR WIFE never married	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) ~~XXXXXXX~~	16. SOCIAL SECURITY NO. none	17. INFORMANT Charles M. Schafer-father-15 W. 61st Terr. Address	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Aplastic anemia — INTERVAL BETWEEN ONSET AND DEATH 6 mo.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)

DUE TO (c) 2924

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

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 4-24-57, to 10-8-57 and last saw him alive on 10-8-57

Death occurred at 1 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Raymond B Anderson MD	22b. ADDRESS 411 Nichols Rd	22c. DATE SIGNED 10-8-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/11/57	23c. NAME OF CEMETERY OR CREMATORY CALVARY CEMET.
23d. LOCATION (City, town, or county) (State) Kansas City, Missouri		
24. FUNERAL DIRECTOR ADDRESS QUIRK & TOBIN 20 W. Linwood, K.C.Mo.	25. DATE RECD. BY LOCAL REG. 10-11-57	26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Raymond B. Anderson

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 E. C. Gibson

Licensed Embalmer No. 4137

P. O. Address K. C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure 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.