

v. Health,  
& Welfare  
S. Public  
th Service

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v. 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Carcasses cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
Martin J. Mueller

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED NOV 20 1957

40592

STATE FILE NUMBER 5155

Registration District No. 147 Primary Registration District No. 005 Registrar's No.

1. PLACE OF DEATH a. COUNTY Jackson			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE Missouri b. COUNTY Jackson		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4109 Paseo		Length of stay in lb Life		d. STREET ADDRESS 4109 Paseo (If outside, give location)	
3. NAME OF DECEASED (Type or print) First FLORA Middle Louise Last SCHURKE			4. DATE OF DEATH Month 11 Day 1 Year 57		
5. SEX Fe	6. COLOR OR RACE Wh	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-25-1893	9. AGE (In years last birthday) 64 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) Com. Operator		100. KIND OF BUSINESS OR INDUSTRY Dept. Store		11. BIRTHPLACE (City and state or country) Kansas City, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Adam Hammann			14. MOTHER'S MAIDEN NAME Catherine Schopp Schaab		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No xx		16. SOCIAL SECURITY NO. 486-09-3444		17. INFORMANT Address Mrs. Chas. L. Schmidt, 1020 W. 41st	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Coronary Arterio Sclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus					INTERVAL BETWEEN ONSET AND DEATH 5 years
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 7-5-50 to 11-1-57 and last saw her alive on 9-15-57 Death occurred at 4:45 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Martin J. Mueller M.D.			22b. ADDRESS 535 Angye Bldg KCMO		22c. DATE SIGNED 11-4-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11-5-57		23c. NAME OF CEMETERY OR CREMATORY Forest Hill Cem.	
		23d. LOCATION (City, town, or county) Kansas City		(State) Mo.	
24. FUNERAL DIRECTOR ADDRESS Wagner Funeral Home, KCMO			25. DATE RECD. BY LOCAL REG. 11-4-57		26. REGISTRAR'S SIGNATURE Irene Trinchell

(Licensed Embalmer's Statement on Reverse Side)

V-2-8-27  
10/1/27



**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 *Alvin R. Haunschild*

Licensed Embalmer No. *415*

P. O. Address *K. C. W.*

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.