

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-032971

STATE FILE NUMBER

FILED OCT 15 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4566

5. 300
1-57

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTE <u>Walnut Nursing Home</u>		Length of stay in lb <u>71 yrs.</u>		d. STREET ADDRESS (If outside, give location) <u>4335 WABASH</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANK WILLIAM SCHROER</u>				4. DATE OF DEATH Month Day Year <u>Sept-27-1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-17-1885</u>	9. AGE (In years) Months Days Hours Min. <u>73</u>		10. UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Letter Carrier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Postal Dept.</u>		11. BIRTHPLACE (City and state or country) <u>Seaside, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John Schroer</u>		13b. MOTHER'S MAIDEN NAME <u>Ella Partridge</u>		14. NAME OF HUSBAND OR WIFE <u>Hayel M. Schroer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mr. Hayel Schroer</u> Address <u>4335 Wabash</u> <u>I.E. Mo.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Hypostatic pneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>cerebral vascular accident</u>						<u>1 month</u>	
DUE TO (c) <u>Hypertension</u>						<u>4 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>3317</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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 <u>1950</u> to <u>Sept 27/1958</u> and last saw her alive on <u>9/24/58</u> . Death occurred at <u>Walnut Nursing Home</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>E. J. Gehrke</u>				22b. ADDRESS <u>14002 E 31st K.P. Mo</u>		22c. DATE SIGNED <u>9/27/58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Sept 29-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Moriah Cemetery</u>		23d. LOCATION (City, town, or country) (State) <u>Kansas City, Mo.</u>		
24. FUNERAL DIRECTOR <u>C.H. Blackburn & Son Inc.</u>				25. DATE RECD. BY LOCAL REG. <u>9-27-58</u>		26. REGISTRAR'S SIGNATURE <u>neva Trinchell</u>	

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

E. J. Gehrke



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 *W. C. Rinne*

Licensed Embalmer No. *4829*

P. O. Address *J. C. Mu.*

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.