

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-001508

STATE FILE NUMBER

285

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 285

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City Inside Limits Yes No
c. FULL NAME OF HOSPITAL OR INSTITUTION Seaside Hospital Length of stay in 1b 1 day
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri S. COUNTY Jackson
c. CITY OR TOWN Kansas City Inside Limits Yes No
d. STREET ADDRESS (If outside, give location) 3121 Harrison Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last Jonathan Del Schultz
4. DATE OF DEATH Month Day Year Jan 12 1959
5. SEX Male 6. COLOR OR RACE White 7. MARRIED NEVER MARRIED WIDOWED DIVORCED
8. DATE OF BIRTH Jan 11 1959 9. AGE (In years last birthday) 1 IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant 10b. KIND OF BUSINESS OR INDUSTRY infant 11. BIRTHPLACE (City and state, or country) Kansas City, Mo 12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Unknown 13b. MOTHER'S MAIDEN NAME Judith Ann Trotter 14. NAME OF HUSBAND OR WIFE none
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None 17. INFORMANT Judith Ann Schultz, Kansas City, Mo 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) Apoplexy
DUE TO (b) Pulmonary A-falini Meningeane 18 Day.
DUE TO (c) Decease due to Pre-maturity w.t. 320.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Pre-mature weight 3 lb. 7.
19. WAS AUTOPSY PERFORMED? YES 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 Month, Day, Year a.m. p.m.
20d. INJURY OCCURRED WHILE AT 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 January 12-59 to January 12-59 and last saw ^{him} alive on January 12, 1959
Death occurred at 4:59 P. on the date stated above; and to the best of my knowledge, from the causes stated.
22a. SIGNATURE John G. Robinson (Doctor or Nurse) 22b. ADDRESS 505 East 85th K.C. Mo 22c. DATE SIGNED 1-13-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Buried 23b. DATE 1-15-59 23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery 23d. LOCATION (City, town, or county) (State) Kansas City, Mo.
24. FUNERAL DIRECTOR ADDRESS Sidmon Mortuary, K. C. Mo. 25. DATE RECD. BY LOCAL REG. 1-15-59 26. REGISTRAR'S SIGNATURE neva Marshall

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare Public Service

300
1-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
All diseases in Part I must be causally related.
John A. Robinson

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 *John R. Bidm*

Licensed Embalmer No. *453*

P. O. Address. *Janice*

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.