

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-021686

STATE FILE NUMBER

FILED JUL 13 1959

Registration District No. \_\_\_\_\_

149

Primary Registration District No. \_\_\_\_\_

1002

Registrar's No. \_\_\_\_\_

3068

300  
-57

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>Menorah Medical Center</b>		Length of stay in lb <b>70 YRS.</b>	d. STREET ADDRESS (If outside, give location) <b>417 E. 73rd Terrace</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Winnifred</b> Middle <b>W.</b> Last <b>Schumacher</b>			4. DATE OF DEATH Month <b>June</b> Day <b>21st</b> Year <b>1959</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 16th, 1982</b>	9. AGE (In years, if UNDER 1 YEAR, give Months, Days, Hours, Min.) <b>77 YRS</b>	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SOCIAL WELFARE WORKER</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>HINGHAM, MASS</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>FRED M WEBBER</b>		13b. MOTHER'S MAIDEN NAME <b>EVA JOHNSON</b>		14. NAME OF HUSBAND OR WIFE <b>FRANK A SCHUMACHER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>488 36 0914</b>	17. INFORMANT Address <b>FRANK SCHUMACHER 6126 KENWOOD</b>		
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>Old and recent myocardial infarction</b>				INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <b>Coronary atherosclerosis - 4201</b>				<b>20 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Acute bronchopneumonia; right lower lobe</b>					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ a.m. _____ p.m. Month, Day, Year _____					
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>1947</b> , to <b>June 21, 1959</b> and last saw her alive on <b>June 21, 1959</b> Death occurred at <b>7155 A.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Cecil M. Kohn MD</b>			22b. ADDRESS <b>751-E-63rd</b>		22c. DATE SIGNED <b>6/23/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>JUNE 24, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MEMORIAL PARK</b>		23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY, MO</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Old Newcomer's Sons.</b>			25. DATE RECD. BY LOCAL REG. <b>6-23-59</b>	26. REGISTRAR'S SIGNATURE <b>Irene Minshall</b>	

MEDICAL CERTIFICATION  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
Cecil M. Kohn

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 *Roan Fuller* .....

Licensed Embalmer No. *4818* .....

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.