DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59-029307

STATE FILE NUMBER

FILED VS AUG 21 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3812

1. PLACE OF DEATH
a. COUNTY: Jacks on
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Kansa s City
Length of stay in 1b: 1 day
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Conley Maternity Hospital
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY: Jackson
c. CITY OR TOWN: Kansas City
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 4924 Wabash
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: John Middle: Charles Last: Schwark
4. DATE OF DEATH: Month: August Day: 6, Year: 1959
5. SEX: male
6. COLOR OR RACE: white
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: Aug 5, 1959
9. AGE (last birthday)
IF UNDER 1 YEAR: Months / Days: 1
IF UNDER 24 HR: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (City and state or country): Kansas City, Missouri
12. CITIZEN OF WHAT COUNTRY: U. S. A.
13a. FATHER'S NAME: Charles B. Schwark
13b. MOTHER'S MAIDEN NAME: Judy L. Tiemann
14. NAME OF HUSBAND OR WIFE: none
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Charles B. Schwark Address: 4924 Wabash

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): Cardiac + Respiratory Exhaustion
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Prematurity 24 to 25 weeks
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown
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 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 8-5-59, to 8-6-59 and last saw her/him alive on 8-6-59
Death occurred at 12:10 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Lee E Davidson DO
22b. ADDRESS: 2105 Independence
22c. DATE SIGNED: 8-6-59
23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE: Aug. 6, 1959
23c. NAME OF CEMETERY OR CREMATORY: Floral Hills Cemetery
23d. LOCATION (City, town, or county) (State): Kansas City, Missouri
24. FUNERAL DIRECTOR ADDRESS: Earp & Sons 4707 Truman Rd. K.C. Mo.
25. DATE RECD. BY LOCAL REG.: 8-6-59
26. REGISTRAR'S SIGNATURE: Neva Marshall

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed William H. Earp

Licensed Embalmer No. 472

P. O. Address K. C. 9

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