

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. FEB 15 1960 149

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Primary Registration District No. 1002 Registrar's No.

529-60-001870
STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 28 Years		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 St. Joseph Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1110 Oakley		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Thomas Schejbal				4. DATE OF DEATH Month Day Year January 28th 1960				
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 3-31-1888	9. AGE (last birthday) 71	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Glazier (retired)		10b. KIND OF BUSINESS OR INDUSTRY Ford Motor Co.		11. BIRTHPLACE (City and state or country) Czechoslovakia		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME John Schejbal			13b. MOTHER'S MAIDEN NAME Katherine Kunces			14. NAME OF HUSBAND OR WIFE Mrs. Stella Schejbal		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 486-05-1840		17. INFORMANT Address Mrs. Stella Schejbal 1110 Oakley K.C., Mo.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Systemic Retroperitoneal Hemorrhage DUE TO (b) Multiple fractures Pelvis DUE TO (c) Ribs						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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) Redstream Struck by Car						
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. 1-25-60		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street office bldg., etc.) Street		20f. CITY, TOWN, OR LOCATION COUNTY STATE Kansas City Jackson MO		
21. I attended the deceased from _____ to _____ and last saw him/her alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) Hugh A. Owens Coroner				22b. ADDRESS 1034 Riatta Bldg			22c. DATE SIGNED 1-29-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2-1-60	23c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant		23d. LOCATION (City, town, or county) Kansas City, Mo.		(State)	
24. FUNERAL DIRECTOR Shell Funeral Home Kansas City, Mo.				25. DATE RECD. BY LOCAL REG. 1-29-60	26. REGISTRAR'S SIGNATURE new Marshall			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF
High Owens

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.