

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-011226

FILED VS. APR 11 1960

149

Registration District No. Primary Registration District No. 1002

Registrar's No. 1802

STATE FILE NUMBER

UNDECEASED

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jackson				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 18 yrs		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) 2634 Spruce		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDWARD Middle L. Last SCHMALFELDT				4. DATE OF DEATH Month 3 Day 27 Year 60				
5. SEX Ma	6. COLOR OR RACE Wh	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 6-20-99	9. AGE (last birthday) 60	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist			10b. KIND OF BUSINESS OR INDUSTRY Bendix Corp.		11. BIRTHPLACE (City and state or country) Lone Elm, Mo.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Wm. Schmalfeldt			13b. MOTHER'S MAIDEN NAME Johana Brandes			14. NAME OF HUSBAND OR WIFE Sophia M. Schmalfeldt		
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. 499-14-5987		17. INFORMANT Mrs. Sophia M. Schmalfeldt, Spruce			Address 2634
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Rt lung DUE TO (b) Metastases of CA to liver DUE TO (c) Cirrhosis of Liver Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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							INTERVAL BETWEEN ONSET AND DEATH few weeks unknown 2 years.	
19. WAS AUTOPSY PERFORMED? YES <input 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 8-10-55 to 3-27-60 and last saw him alive on 3-27-60 Death occurred at 12:10 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) William M. Korth MD.				22b. ADDRESS 612 Professional Bldg			22c. DATE SIGNED 3-28-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-29-60	23c. NAME OF CEMETERY OR CREMATORY White Chapel Mem. Gardens		23d. LOCATION (City, town, or county) Clay Co. Mo.		(State)	
24. FUNERAL DIRECTOR Nagner Funeral Home. K C Mo			ADDRESS		25. DATE RECD. BY LOCAL REG. 3-28-60	26. REGISTRAR'S SIGNATURE Steve Marshall		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

William M. Korth

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 Alvin R. Hannon

Licensed Embalmer No. 415

P. O. Address H. C. 7

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.