

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAY 5 1960

60-015619

2168

STATE FILE NUMBER

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

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>		Length of stay in 1b <b>30 yrs.</b>		c. CITY OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. JOSEPH HOSP</b>				d. STREET ADDRESS (If outside, give location) <b>6236 PARK AVE.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>KATHERINE</b> Middle <b>SCHIFFNER</b> Last				4. DATE OF DEATH Month <b>APRIL</b> Day <b>15</b> Year <b>1960</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>JUNE 11, 1893, 76 yrs.</b>	9. AGE (last birthday)	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) <b>HOUSEWIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>RUSSIA</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>WILLIAM SCHULTZ</b>			13b. MOTHER'S MAIDEN NAME <b>KATHERINE Schliner</b>		14. NAME OF HUSBAND OR WIFE <b>CHRISTOPHER SCHIFFNER</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>NONE</b>	17. INFORMANT <b>CHRISTOPHER SCHIFFNER 6236 Park</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>Cocaine thrombosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Pulmonary edema secondary to congestive heart failure</b>						<b>1 week</b>	
DUE TO (c) <b>Hypertensive heart disease</b>						<b>year</b>	
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 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>4-5-60</b> to <b>4-15-60</b> and last saw her alive on <b>4-14-60</b>				Death occurred at <b>2:00 AM</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>John T. Skinner MD</b> (Degree or title)			22b. ADDRESS <b>1102 Grand St. MO</b>		22c. DATE SIGNED <b>4-15-60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>APRIL 18, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FOREST HILL CEM</b>		23d. LOCATION (City, town, or county) <b>KANSAS CITY MO.</b>		23e. (State)	
24. FUNERAL DIRECTOR <b>D. W. NEWCOMER'S SONS K C. MO.</b>			25. DATE RECD. BY LOCAL REG. <b>4-18-60</b>	26. REGISTRAR'S SIGNATURE <b>Debra Marshall</b>			

DOCUMENT

MEDICAL CERTIFICATION  
John T. Skinner

BY AFFIDAVIT OF

**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 Robert F. 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 conform 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.