

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-027120

FILED VS AUG 8 1960

149

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

3834

STATE FILE NUMBER

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 17 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 TRINITY LUTHERAN HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4001 BROOKLYN AVENUE		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MAYME Middle LOU Last SCHATZ			4. DATE OF DEATH Month JULY Day 23 Year 1960		
5. SEX FEMALE	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 MARCH 6, 1930	9. AGE (last birthday) 30
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (City and state or country) EXCELSIOR SPRINGS, MO.	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME KENNETH E. SANDERSON		13b. MOTHER'S MAIDEN NAME LAFON JOHNSON		14. NAME OF HUSBAND OR WIFE BILL C. SCHATZ	
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. -----	17. INFORMANT BILL C. SCHATZ 4001 BROOKLYN AVENUE KANSAS CITY, 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) Acute pancreatitis					INTERVAL BETWEEN ONSET AND DEATH 2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Unknown					
DUE TO (c) -----					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) None known				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 checked="" 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 July 20, 1960 to July 23, 1960 on July 22, 1960 Death occurred at 6:10 A. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) M.B. Casbolt M.D.			22b. ADDRESS 4900 Baltimore		22c. DATE SIGNED 7/23/60
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE JULY 26, 1960	23c. NAME OF CEMETERY OR CREMATORY GREEN LAWN CEMETERY	23d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI		
24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS		25. DATE RECD. BY LOCAL REG. 7-25-60	26. REGISTRAR'S SIGNATURE Neva Marshall		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF M.B. Casbolt

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 Chester K. Brown

Licensed Embalmer No. 493

P. O. Address KO M

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.