

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-027123**

FILED VS AUG 8 1960

Registration District No. 141 Primary Registration District No. 1002 Registrar's No. 3704 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived if admission: Residence before admission) a. STATE <u>Kansas</u> b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in 1b <u>1 wk</u>	c. CITY OR TOWN <u>Jola</u> <u>Kansas City, Mo.</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>General Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>301 North St.</u>
		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Sadie</u> Middle <u>Bell</u> Last <u>Schultz</u>			4. DATE OF DEATH Month <u>7</u> Day <u>16</u> Year <u>60</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-19-1885</u>	9. AGE (last birthday) <u>74</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>De Kalf co. Mo.</u>	11. BIRTHPLACE (City and state or country) <u>U.S.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>		13a. FATHER'S NAME <u>- Aldridge</u>	13b. MOTHER'S MAIDEN NAME <u>- Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Fred R. Schultz</u>

15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Mrs. Maxine Martin</u>	Address <u>Lee's Summit</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<u>temporal lobe infarction</u>	
CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.	DUE TO (b) <u>with extensive subarachnoid hemorrhage</u>	
	DUE TO (c)	

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	
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19. WAS AUTOPSY PERFORMED? YES <input checked="" 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 <u>2:15</u> a.m. p.m.	Month, Day, Year <u>7-5-60</u>		
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 7-5-60 to 7-16-60 and last saw her/him alive on 7-16-60  
Death occurred at 2:15 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>MD</u>	22b. ADDRESS <u>2400 Cherry, K.C. Mo</u>	22c. DATE SIGNED <u>7-16-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>7-16-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Iola, Kansas</u>	23d. LOCATION (City, town, or county) <u>Iola Kansas</u>
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24. FUNERAL DIRECTOR <u>D. W. Newcomer's son</u>	ADDRESS <u>1331 Brushcreek</u>	25. DATE RECD. BY LOCAL REG. <u>7-16-60</u>	26. REGISTRAR'S SIGNATURE <u>Bertha Tinley, Dep</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF DWYER

**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

*Edward M. Stone*

Licensed Embalmer No. 4452

P. O. Address K.C. 107

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.