

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-041153

FILED VS NOV 28 1960

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1201

STATE FILE NUMBER

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| 1. PLACE OF DEATH a. COUNTY Buchanan | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph | | Length of stay in 1b 43 years | c. CITY OR TOWN St. Joseph 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. Josephs Hospital | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 3616 Seneca St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) JENNIE SCHROEDER | First Middle Last | 4. DATE OF DEATH November 13, 1960 | Month Day Year |
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|----------------------|-------------------------------|--|----------------------------------|----------------------------------|--------------------------------|------------------------------|
| 5. SEX female | 6. COLOR OR RACE white | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 7/4/1879 | 9. AGE (last birthday) 81 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HR Hours Min. |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | 10b. KIND OF BUSINESS OR INDUSTRY own home | 11. BIRTHPLACE (City and state or country) Albany, New York | 12. CITIZEN OF WHAT COUNTRY USA |
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| 13a. FATHER'S NAME unknown Callahan | 13b. MOTHER'S MAIDEN NAME unknown | 14. NAME OF HUSBAND OR WIFE A. L. Schroeder |
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| 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. none | 17. INFORMANT Address Mrs. Karl Kapp, 3511 Seneca St., St. Joseph, Mo. |
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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: IMMEDIATE CAUSE (a) Arterioclototic heart disease to coronary failure 2 yrs | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Advanced embolus of the liver - Carcinoma of stomach | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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.) |
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| 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. | 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 |
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| 21. I attended the deceased from 1958 to death and last saw her/him alive on 11/13/60 Death occurred at 4:40 p. on the date stated above, and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE (Degree or title) <i>[Signature]</i> | 22b. ADDRESS <i>[Address]</i> | 22c. DATE SIGNED 11/19/60 |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) burial | 23b. DATE 11/16/1960 | 23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery | 23d. LOCATION (City, town, or county) St. Joseph Mo. |
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| 24. FUNERAL DIRECTOR ADDRESS Heaton Bowman, St. Joseph, Mo. | 25. DATE RECD. BY LOCAL REG. Nov. 22, 1960 | 26. REGISTRAR'S SIGNATURE <i>[Signature]</i> |
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DOCUMENT

BY AFFIDAVIT OF MEDICAL CERTIFICATION

E. Peterson, M.D.

DEC 2 1960
DEC 1 6 1960

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 William Spillman

Licensed Embalmer No. 453

P. O. Address Spokane

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do 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.