

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 19 1960

6048-60-046329

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6048 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</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>2 Years</u>	c. CITY OR TOWN <u>Kansas City</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3111 Linwood</u>		d. STREET ADDRESS (If outside, give location) <u>3111 Linwood</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>OTTILIA</u> Middle <u>KATHERINE</u> Last <u>SCHNAITH</u>			4. DATE OF DEATH Month <u>12</u> Day <u>1</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>10-11-73</u>	9. AGE (last birthday) <u>87</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
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>Own Home</u>	11. BIRTHPLACE (City and state or country) <u>Sauk City, Wis.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>Christian Fiege</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Adolph E. Schnaith</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 Address <u>3111 Linwood</u> <u>Mrs Myrtle M. Kienle K.C. Mo.</u>			

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 <u>15 days.</u>
IMMEDIATE CAUSE (a)	<u>Coronary Thrombosis</u>	
CONDITIONS, if any, which gave rise to above cause (a), stating the underlying cause last.	<u>Generalized arteriosclerosis</u>	
DUE TO (b)	<u>None</u>	
DUE TO (c)	<u>None</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>None</u>		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 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 <u>2:45</u> 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 <u>November 4, 1960, December, 1960</u>	COUNTY <u>St. Louis</u>	STATE <u>Mo</u>
21. I attended the deceased from <u>November 4, 1960</u> to <u>December, 1960</u> and last saw her <u>November 28, 1960</u> alive on <u>2:45 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.				

22. SIGNATURE <u>Carroll P. Hungate M.D.</u> (Degree or title)		22b. ADDRESS <u>535 Oggle Bldg, Kansas City Mo</u>		22c. DATE SIGNED <u>12-2-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>12-2-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oakland</u>		23d. LOCATION (City, town, or county) (State) <u>St. Paul, Minnesota</u>
24. FUNERAL DIRECTOR <u>Wagner Funeral Home - R. E. 7110</u>		25. DATE RECD. BY LOCAL REG. <u>12-2-60</u>	26. REGISTRAR'S SIGNATURE <u>H. L. Sawyer</u>	

DOCUMENT BY AFFIDAVIT OF

Carroll P. Hungate M.D. HUNGATE MEDICAL CERTIFICATION

4-23

11-0-1-12-5-1

**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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.