

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-019106
2406 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2406

FILED MAY 31 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY Johnson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b Life	c. CITY OR TOWN Mission 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. Luke's Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5724 Riggs Road Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last ROBERT JOSEPH SCHMIDT			4. DATE OF DEATH Month Day Year May 1 1962
5. SEX Male	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 3/5/1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Seidlitz Paint & Varnish Co.	11. BIRTHPLACE (City and state or country) Kansas City, Mo. U.S.A.
13a. FATHER'S NAME Leo Schmidt		13b. MOTHER'S MAIDEN NAME Theresa Schneitz	14. NAME OF HUSBAND OR WIFE Clara Schmidt
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 Address Kansas Clara Schmidt, 5724 Riggs, Mission.
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia & inanition			INTERVAL BETWEEN ONSET AND DEATH 2 mos.
DUE TO (b) Metastatic Transitional Cell Carcinoma 1 Year.			
DUE TO (c) Bronchial Carcinoma Rt. Lung. 1 Year.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerotic Heart Disease			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 Sept. 8, 1961 to May 1, 1962 and last saw her alive on April 30, 1962 . Death occurred at 5:10 A. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Philip G. Kaul</i> (Degree or title)		22b. ADDRESS 7320 Wornall Rd. K.C. 11, Mo.	22c. DATE SIGNED 5-1-62
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE May 3, 1962	23c. NAME OF CEMETERY OR CREMATORY Mt. Muncie Cemetery	23d. LOCATION (City, town, or county) Leavenworth Kansas
24. FUNERAL DIRECTOR D.W. Newcomer's Sons, 1331 Brush Creek Blvd. Kansas City, Mo.		25. DATE RECD. BY LOCAL REG. 5-3-62	26. REGISTRAR'S SIGNATURE <i>Ruth Long</i>

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF **Philip G. Kaul**

Dr. Phillip G. Kaul
Pl 4320 Wornall Road
#224
JPM.

STATE OF MISSOURI

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Philo G. Kaul

Licensed Embalmer No. 3035

P. O. Address St. Charles

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.