

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-047182

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149
FILED JAN 7 1963

Primary Registration District No. 1002 Registrar's No. 6572

6572
6572

VS 300 Rev. 4/59	1	3	4	5	6	7	8	9	10	11	12	13
								94201			1253-2	
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS												
INSTEAD OF												
SHOULD READ												
BY AFFIDAVIT OF												

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 lb 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 DOCTORS HOSPITAL			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1609 EAST 81st STREET	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First ANN Middle MARGRETTA Last SCHMIDT			4. DATE OF DEATH Month DECEMBER Day 21st Year 1962		
5. SEX FEMALE	6. COLOR OR RACE CAUCASIAN	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4/6/1891	9. AGE (last birthday) 70 7/1	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER		10b. KIND OF BUSINESS OR INDUSTRY SCHOOL	11. BIRTHPLACE (City and state or country) LeMars, Iowa		12. CITIZEN OF WHAT COUNTRY U. S. A.
13a. FATHER'S NAME JENS P. SCHMIDT		13b. MOTHER'S MAIDEN NAME MARIE NELSON		14. NAME OF HUSBAND OR WIFE -----	
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 CHRISTINE SCHMIDT Address 1609 EAST 81ST ST KANSAS CITY, MO.	
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) VENTRICULAR FIBRILLATION DUE TO (b) MYSCARDIAL INFARCTION DUE TO (c) CORONARY OCCUSION 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					INTERVAL BETWEEN ONSET AND DEATH 1 WK 1 WK
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 checked="" 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 <u>12/15/62</u> to <u>12/21/62</u> and last saw her alive on <u>12/21/62</u> Death occurred at <u>8:30 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) J. Rosen D.O.			22b. ADDRESS 576 12th WALNUT DR '6		22c. DATE SIGNED 12/21/62
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE DEC. 24, 1962	23c. NAME OF CEMETERY OR CREMATORY FLORAL HILLS CEMETERY		23d. LOCATION (City, town, or county) KANSAS CITY MISSOURI	(State)
24. FUNERAL DIRECTOR D.W. Newcomer's Sons, Kansas City, Mo.		25. DATE RECD. BY LOCAL REG. 12-24-62	26. REGISTRAR'S SIGNATURE Ruth Long		

Dr. Jacob Rosen D.D.
1214 Walnut St Bldg Room 516
12:00 - 2:00

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 Dean W. Huff

Licensed Embalmer No. 4914

P. O. Address Indy, Mo.

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.