

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-040142
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5467

FILED OCT 24 1963

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u> Length of stay in lb <u>3 WEEKS</u> c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. JOSEPH'S HOSPITAL</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> COUNTY <u>JASPER</u> c. CITY OR TOWN <u>CARTHAGE</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>1424 ROBERTSON</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>CONIE</u> Last <u>SCHAIFF</u>	4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>7</u> Year <u>1963</u>
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9/20/1895</u>	9. AGE (last birthday) <u>68</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WESTERN UNION</u>	11. BIRTHPLACE (City and state or country) <u>SAYRE ARKANSAS</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>
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13a. FATHER'S NAME <u>JACOB C. SCHAIFF</u>	13b. MOTHER'S MAIDEN NAME <u>SUSIE DEW</u>	14. NAME OF HUSBAND OR WIFE <u>MRS. WILMA I. SCHAIFF</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES WORLD WAR I</u>	16. SOCIAL SECURITY NO. <u>[REDACTED]</u>	17. INFORMANT <u>MRS. WILMA I. SCHAIFF</u> Address <u>1424 ROBERTSON CARTHAGE MO</u>
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18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO (b) <u>Hepatomia</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> "
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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) <u>Hypostatic pneumonia</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 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 _____ 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
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21. I attended the deceased from 9-17-63 to 10-7-63 and last saw him alive on 10-7-63
 Death occurred at 9:45 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>[Signature]</u>	22b. ADDRESS <u>5246 St. John</u>	22c. DATE SIGNED <u>10/7/63</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>OCT. 9, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FLORAL HILLS CEMETERY</u>	23d. LOCATION (City, town, or county) <u>KANSAS CITY MISSOURI</u>
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24. FUNERAL DIRECTOR <u>D.W. NEVCOMER'S SONS</u> ADDRESS <u>1931-BRUSH CREEK KANSAS CITY, MO</u>	25. DATE RECD. BY LOCAL REG. <u>10-9-63</u>	26. REGISTRAR'S SIGNATURE <u>Beasie Smith</u>
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(Licensed Embalmer's Statement on Reverse Side)

DO NOT WRITE ON THIS STUB
 AMENDED
 VS 300 Rev. 4/59
 1
 2 0487
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 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 SHOULD READ
 ITEM NO.
 BY AFFIDAVIT OF
 DOCUMENT
 MEDICAL CERTIFICATION
 A. Kienberger

USE BLACK INK OR TYPEWRITER RIBBON

Dr. Paul Elliott Rosenberg
5246 N. Green Avenue
11:50 AM '44

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 Paul J. Hayes

Licensed Embalmer No. 4893

P. O. Address Greenwood, N.Y.

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.