

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-044255
6361 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

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

FILED DEC 11 1963

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>KANSAS CITY</u>		c. CITY OR TOWN <u>KANSAS CITY</u>	
Length of stay in 1b <u>50 YEARS</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>401 EAST 36TH STREET HYDE PARK NURSING HOME</u>		d. STREET ADDRESS (If outside, give location) <u>401 EAST 36TH STREET</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EMMA KATHERINE SCHUCHMANN</u>			4. DATE OF DEATH Month Day Year <u>NOVEMBER 21 1963</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>12-9-1877</u>
9. AGE (last birthday) <u>85</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE - AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>	11. BIRTHPLACE (City and state or country) <u>WARRENTON, MISSOURI</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>AUGUST HALSTENBERG</u>	
13b. MOTHER'S MAIDEN NAME <u>ELIZABETH ROTERT</u>		14. NAME OF HUSBAND OR WIFE <u>GEORGE R. SCHUCHMANN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <u>No</u>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>Mrs. HELEN ERWINE - KANSAS CITY, MISSOURI</u>		Address <u>738 1/2 HARRISON STREET</u>	
18. CAUSE OF DEATH (Enter only one cause per time for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure - arteriosclerotic heart disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Five months</u>
DUE TO (b) <u>Arteriosclerosis - generalized</u>			
DUE TO (c) <u>old age - arthritis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Bed patient years arthritis</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
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SLIIDE <input checked="" 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>July 15/1963</u> to <u>11/21/63</u> and last saw her/him alive on <u>11/14/63</u> Death occurred at <u>12:15 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Hester J. Wilson MD</u>		22b. ADDRESS <u>411 Nichols Road</u>	22c. DATE SIGNED <u>11/21/63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>NOV. 23, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. MORIAH CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MISSOURI</u>
24. FUNERAL DIRECTOR <u>D.W. NEWCOMER'S SONS</u>		25. DATE RECD. BY LOCAL REG. <u>11-22-63</u>	26. REGISTRAR'S SIGNATURE <u>Bessie Smith</u>

USE BLACK INK OR TYPEWRITER RIBBON

Hester J. Wilson MEDICAL CERTIFICATION

2025-01-08

St. Heaton P. Nelson
233 Pledge
100-5160
Travis Bell
411 Industrial Road

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 Robert M. Boyer

Licensed Embalmer No. 4892

P. O. Address Overland Park, KS

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.