

REC'D FEB 21 1939

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

2610

Do not use this space.

## 1. PLACE OF DEATH

(a) County Jackson Registration District No. 400  
(b) Township Prarie Primary Registration District No. 5533 B  
(c) City ..... (d) Street No. Jackson County Home St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

## 2. PRINT FULL NAME

Martin L. Schanze  
(a) Residence, No. 3011 College St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Bring the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 13 1878

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
65 5 9 18

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None  
9. Industry or business in which work was done, as saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown ?

13. NAME John Schanze 1

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany 1

15. MAIDEN NAME Anna Reed

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas

17. INFORMANT (ADDRESS) John Schanze

18. BURIAL, CREMATION, OR REMOVAL PLACE Calvary Church DATE Feb 4 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) P. J. Higgins  
2512 Halsted St.

20. FILED 2-3- 1939 William J. Fields Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 31 7:30 am 39

22. I HEREBY CERTIFY That I attended deceased from Jan 1 1939 to Jan 31 1939  
last saw him alive on 1-30 1939 Death is said to have occurred on the date stated above, at ..... m.  
The principal cause of death and related causes of importance were as follows:

chronic myocarditis Date of onset

Other contributory causes of importance: 42

Name of operation ..... Date of .....  
What test confirmed diagnosis clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? ..... Date of injury ..... 19.....  
Where did injury occur? ..... (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....  
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? no  
If so, specify .....  
(Signed) W. Green M. D.  
(Address) St. Louis

Dr. J. G. Green Carl Bldg.  
Independence

W.E. Field  
Lee Summit

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**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.....

....., Registered Apprentice No.....

working under my personal supervision.

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 this body is not embalmed, above space should be left blank.**