

REC'D JUN 8 1939

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

17767

Do not use this space.

1. PLACE OF DEATH
(a) County Jackson Registration District No. 399
(b) Township Kaw Primary Registration District No. 1002
(c) City K. C. Mo. (d) Street No. 5115 Walnut 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. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Mrs. Emilie Schekorra
(a) Residence, No. 5115 Walnut 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 15, 1867

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
	<u>71</u>	<u>9</u>	<u>8</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. At Home

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) Deutsch Eylau, Ger.

FATHER

13. NAME No Record

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

MOTHER

15. MAIDEN NAME No Record

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

17. INFORMANT Fred W. Schekorra
(ADDRESS) 5115 Walnut

18. BURIAL, CREMATION, OR REMOVAL
PLACE Green Lawn DATE May 24 1939

19. FUNERAL DIRECTOR (NAME) John W. Wagner
(ADDRESS) Kansas City, Mo.

20. FILED May 24 1939 M. M. Brown
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 23, 1939

22. I HEREBY CERTIFY, That I attended deceased from Mar. 9, 1939 to May 23, 1939
I last saw her alive on May 22, 1939 Death is said to have occurred on the date stated above, at 3:10 am
The principal cause of death and related causes of importance were as follows:
Cardiac Failure (Chronic)
Intercostal Myocarditis
Date of onset 930

Other contributory causes of importance:

Name of operation..... Date of.....
What test confirmed diagnosis None..... 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) E. F. Pease
(Address) Seaside Hospital

Dr. G. F. Pease

(Lakeside Hospital)

Office-29th & Flora

LI 0408

Ernest G. Pease

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.