DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 35187

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 4162

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Trinity Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 weeks. (Specify whether

In this community 30 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. 1 (b) County Jackson

(c) City or town Kansas City (If outside city or town limits, write "RURAL")

(d) Street No. 6719 Oak (If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME Carl R. Schafer

3. (b) If veteran, name war no.

3. (c) Social Security No. 486-10-3612

4. Sex Male

5. Color or race wh.

6. (a) Single, widowed, married, divorced Mar.

6. (b) Name of husband or wife Katherine Schafer

6. (c) Age of husband or wife if alive 46 years

7. Birth date of deceased Jan. 4 1890 (Month) (Day) (Year)

8. AGE: Years 49 Months 9 Days 24. If less than one day ..... hr. ..... min.

9. Birthplace Ft. Madison Iowa. (City, town, or county) (State or foreign country)

10. Usual occupation Hard Wood Lumber

11. Industry or business North Mahoney

FATHER
12. Name Chas. Schafer.
13. Birthplace Burlington Iowa (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Lina Aicher
15. Birthplace Mrs. Moines (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Kathryn Schafer

(b) Address 6719 Oak Sh.

17. (a) M. Bierfeld (Burial, cremation, or removal) (b) Date thereof Oct. 30-39 (Month) (Day) (Year)

(c) Place: burial or cremation Mt Moriah

18. (a) Signature of funeral director Eylar Funeral Home

(b) Address K. C. Mo.

19. (a) 10/30/39 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 28 year 1939 hour 6 minute — M.

21. I hereby certify that I attended the deceased from Oct 1-1939 to Oct 28, 1939, to —, 19..; that I last saw him alive on Oct 28, 1939; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Lung abscess	6 wks
Rupture of lung & abscess	48 hrs
Due to Post-Tonsillectomy about 9-15-39	
Due to	
Other conditions none (Include pregnancy within 3 months of death)	

Major findings:
Of operations none.
Of autopsy Rupture of lung & abscess into pleural cavity

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature Allen L. Hearst (M. D. or other) 1

Address 1100 Prof. Bldg Date signed 10-29-39

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Rev. 5-17-39 I X19511

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 Chas Wicks

Licensed Embalmer No. 2644

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.