No. 2
1-10-39
17-39
X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 13866

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 157

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: 4317 Bellefontaine
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: (Specify whether years, months or days)
In this community: All his life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jackson
(c) City or town: Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No.: 4317 Bellefontaine
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ... years.

3. (a) PRINT FULL NAME: FRANK EDWARD SCHOSTER 236
3. (b) If veteran, name war: No
3. (c) Social Security No.: None
4. Sex: Ma
5. Color or race: Wh
6. (a) Single, widowed, married, divorced: Widowed
6. (b) Name of husband or wife: Mrs. Caroline Schoster
6. (c) Age of husband or wife if alive: -- years
7. Birth date of deceased: June (Month) 17 (Day) 1874 (Year)

8. AGE: Years 65 Months 9 Days 23 If less than one day ... hr. ... min.

9. Birthplace: Kansas City (City, town, or county) Missouri (State or foreign country)
10. Usual occupation: Retired
11. Industry or business: 6
FATHER
12. Name: Gerhardt Schoster
13. Birthplace: Germany (City, town, or county) (State or foreign country) 6
MOTHER
14. Maiden name: Wilhelmina Dunsing
15. Birthplace: Germany (City, town, or county) (State or foreign country)
16. (a) Informant: Josephine Schoster
(b) Address: 4317 Bellefontaine
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4-13-1940 (Month) (Day) (Year)
(c) Place: burial or cremation: Forest Hill Cemetery
18. (a) Signature of funeral director: J W Wagner
(b) Address: K. C. Mo
19. (a) April 12, 1940 (Date received local registrar) (b) ... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 10th year 1940 hour 3 minute P.M.
21. I hereby certify that I attended the deceased from Dec 31, 1938, to Apr 10, 1940 that I last saw him alive on Apr 10, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinomatosis — Duration
Due to: Carcinoma of prostate 6 5 1
Due to:
Other conditions (Include pregnancy within 3 months of death):
Major findings: Of operations:
Of autopsy:

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: 1

23. Signature: Wm R. Jackson (M. D. or other)
Address: 1107 Bryant Date signed: 4/12/40

(Licensed Embalmer's Statement on Reverse Side)

VI 0848
Bryant Bg
1 to 5

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 Cecil R Matthews

Licensed Embalmer No. 3807

P. O. Address K C Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

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