

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

JUN 17 1940

Registration District No. 399

Primary Registration District No. 1002

Registrar's No.

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:  
K.C. General Hospital No. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 weeks  
(Specify whether  
In this community 20 Yrs.  
years, months or days)

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. 3016 Cambell  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Joseph Schofield 1143

3. (b) If veteran, No. \_\_\_\_\_ 3. (c) Social Security No. no.

4. Sex Male 5. Color or race Wh. 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Myrtle Schofield 6. (c) Age of husband or wife if alive 35 years  
7. Birth date of deceased May 5 1888  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
52 0 25 hr. \_\_\_\_\_ min.

9. Birthplace Philadelphia Pa.  
(City, town, or county) (State or foreign country)

10. Usual occupation Bookkeeper

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Jos. F. Schofield  
13. Birthplace Unknown Pa.  
(City, town, or county) (State or foreign country)  
14. Maiden name Bessie Entenman  
15. Birthplace Unknown Pa.  
(City, town, or county) (State or foreign country)

16. (a) Informant Myrtle Schofield  
(b) Address 3016 Cambell  
17. (a) Burial (b) Date thereof June-1-40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Mt. Moriah

18. (a) Signature of funeral director Eylar Funeral Home  
(b) Address 1800 Linwood K.C. Mo

19. (a) May 31, 1940 (b) M. M. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 30th  
year 1940 hour 8 minute 35 A. M.

21. I hereby certify that I attended the deceased from May 24th, 1940, to May 30th 1940, 1940;  
that I last saw him alive on May 30th, 1940, 1940;  
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchogenic carcinoma of left lung with erosion into pericardium

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy See above

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury 1

23. Signature P. H. De Morra M.D. (M. D. or other)  
Address Supt. K.C. Gen. Hospital, K.C. Mo Date signed \_\_\_\_\_

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

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

**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. W. [Signature]*

Licensed Embalmer No.

*2644*

P. O. Address

*1700 [Signature]*

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

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