No. 2
4-13-40
-17-39
I X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34440

VOID NOV 12 1940

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 3956

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

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. M.T.B. Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether
In this community 6 mos - 2 days
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. 712 Garfield
(If rural, give location)

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

3. (a) PRINT FULL NAME Alberta Scherlinger

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Otto

6. (c) Age of husband or wife if alive 37 years

7. Birth date of deceased December (Month) 16 (Day) 1909 (Year)

8. AGE: Years 30 Months 11 Days 28 If less than one day ____ hr. ____ min.

9. Birthplace ____ (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Albert Pitzer
13. Birthplace unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Adeline Manning
15. Birthplace unknown (City, town, or county) (State or foreign country)

16. (a) Informant K.C. M.T.B. Hosp.
(b) Address Leeds Station K.C. Mo

17. (a) Removal & Burial (Burial, cremation, or removal) (b) Date thereof 10 (Month) 16 (Day) 1940 (Year)
(c) Place: burial or cremation Higginsville Mo

18. (a) Signature of funeral director Hadler & Menenhagen
(b) Address Higginsville Mo

19. (a) 10-14-40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 14
year 1940 hour 7 minute 25 A.M.

21. I hereby certify that I attended the deceased from April 12, 1940, to Oct 14, 1940;
that I last saw her alive on Oct 14, 1940
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pulmonary 2B	
Due to 23	
Due to	
Other conditions Diabetic (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

23. Signature O. Hugh Mer (M. D. or other)
Address K.C. T.B. Hospital Kansas City Mo. Date signed 10-14-40

(Licensed Embalmer's Statement on Reverse Side)

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

C G Memershagen, Registered Apprentice No.

working under my personal supervision.

Signed C G Memershagen

Licensed Embalmer No. 1095

P. O. Address

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

If this body is not embalmed, fact should be so stated above.