

No. 2
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17-39
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FILED FEB 28 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **1247**
207
Registrar's No. _____

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH: **Jackson**
(a) County _____
(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. General Hospital
(If not in hospital or institution, write street number or location) 0
(d) Length of stay: In hospital or institution 1 Mo. & 4 days
(Specify whether _____)
In this community life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson **48**
(c) City or town Kansas City **49**
(If outside city or town limits, write "RURAL")
(d) Street No. 2403 Indiana 0
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME John W. Schoenborn

3. (b) If veteran, name war. none 3. (c) Social Security No. unknown

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Mary Schoenborn 6. (c) Age of husband or wife if alive 45 years

7. Birth date of deceased March 1, 1883
(Month) (Day) (Year)

8. AGE: Years 57 Months 10 Days 10 If less than one day hr. _____ min. _____

9. Birthplace Palmira (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation _____

11. Industry or business Helper at St. Lukes Hospital

MOTHER FATHER { 12. Name unknown
13. Birthplace unknown 9
(City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mary Schoenborn
(b) Address N.P. Mo

17. (a) Burial (b) Date thereof 1-14-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenland, Cal.

18. (a) Signature of funeral director H. Tiganian & Sons
(b) Address N.P. Mo

19. (a) Jan 14 1941 (b) M. M. Brown
(Data received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 11th
year 1941 hour 8 minute 27 P. M.

21. I hereby certify that I attended the deceased from 12-8-1940, 19____, to 1-11-1941, 19____; that I last saw him alive on 1-11-1941, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia

Due to Lung abscesses; massive pleural Effusion

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)
(c) Means of injury 0

23. Signature Dwight R. Howard (M. D. or other)
Address Med. Dir. K.C. Gen. Hospital 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.....

Francis Walton
.....
working under my personal supervision.

....., Registered Apprentice No. *2744*

Signed *Francis Walton*
By J. H. Pigeon

..... Licensed Embalmer No. *2744*

..... P. O. Address *K.C. Mo.*

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; fact should be so stated above.