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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

RECEIVED MAR 24 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 5955 727

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

48
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: 2709 Elmwood (If not in hospital or institution, write street number or location)

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

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Jackson 48

(c) City or town K.C. (If outside city or town limits write "RURAL")

(d) Street No. 2709 Elmwood (If rural, give location)

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

3. (a) PRINT FULL NAME: JOHN C. SCHULTZ

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased unknown (Month) (Day) (Year)

8. AGE: Years approx 80 | Months | Days | If less than one day hr. min.

9. Birthplace Germany 4 (City, town, or county) (State or foreign country)

10. Usual occupation retired

11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown 9 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name unknown
15. Birthplace unknown 9 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Elizabeth Williamson

(b) Address 2709 Elmwood

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-19-41 (Month) (Day) (Year)

(c) Place: burial or cremation Highland P.K. K.C.K.

18. (a) Signature of funeral director [illegible]

(b) Address K.C. Mo.

19. (a) 2/18/41 (Date received local registrar) (b) M. M. Crow (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day 2-16-41

year hour minute M.

21. I hereby certify that I attended the deceased from 11 15 a. 19 to 19 ; that I last saw him alive on 19 ; and that death occurred on the date and hour stated above.

Reporting Caronia

	Duration
In medical cause of death	
Acute pulmonary congestion	
Due to	
Acute coronary occlusion	
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, in farm, in industrial place, in public place? (Specify type of place)

While at work (e) Means of injury

23. Signature [illegible] (M. D. or other)

Address K.C. Mo. Date signed

(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 Francis Walton, Registered Apprentice No. 2744 working under my personal supervision.

Signed J. K. Tegeman

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 wi the above constitutes grounds for revocation of license.)

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