

No. 2
-1-4-41
5-17-39
X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

41208

State File No.

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 1989

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution 6229 East 14th
(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 35 years / (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City, Mo. 048
(If outside city or town limits, write "RURAL")

(d) Street No. 6229 East 14th St.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME CHARLES FREDRICK SCHAD

3. (b) If veteran, name war no

3. (c) Social Security No. no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 30 year 41 hour 11 minute 17 A. M.

21. I hereby certify that I attended the deceased from May 41, 1941, to 12/30/41, 1941; that I last saw him alive on 12/28/41, 1941; and that death occurred on the date and hour stated above.

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

6. (b) Name of husband or wife Susie Schad 6. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased January 16 1861
(Month) (Day) (Year)

Immediate cause of death Carcinoma - Bladder metastasis

Duration about 1 year

8. AGE: Years 80 Months 11 Days 14 If less than one day hr. _____ min. _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations 128

Of autopsy none

9. Birthplace Reverna Ohio
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Broommaker

MOTHER FATHER

11. Industry or business _____

12. Name Louis Ludwig Schad

13. Birthplace Sarantzen Germany
(City, town, or county) (State or foreign country)

14. Maiden name Mary Cathine Muehler

15. Birthplace Wittenberg Germany
(City, town, or county) (State or foreign country)

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs Susie Schad

(b) Address 6229 E. 14th St. K.C., Mo.

17. (a) Removal (b) Date thereof 1-2-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Salomon Kansas

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? _____

18. (a) Signature of funeral director W.D. Smith

(b) Address W. D. Smith 55 Kansas

19. (a) Jan 31 1942 (Date received local registrar) M. H. Grow (Registrar's signature)

While at work? _____ (Specify type of place)

(e) Means of injury _____

21. Signature Olaf Calverman (M. D. or other) L.D.

Address 60470 E. 15th St. Mo. Date signed 12/31/41

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.....

Harry E. Jolley

Licensed Embalmer No. *4078*

P. O. Address *Kansas City, Mo.*

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

Registration District No.

Primary Registration District No.

Registrar's No. 4889

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

1. PLACE OF DEATH:

(a) County
(b) City or town
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 6229-6 141
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether)
In this community (Specify whether)
years, months or days

3. (a) PRINT FULL NAME Chas. J. Schad

3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex M 5. Color or race 6. (a) Single, widowed, married, divorced
6. (b) Name of husband or wife 6. (c) Age of husband, or wife, if alive years

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

8. AGE: Years 80 Months Days If less than one year min.

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

10. Usual occupation

11. Industry or business

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 3/30/42 (b) M. M. Crowe (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(c) City or town (If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years

20. DATE OF DEATH Month Dec day 30
year 1941 hour minute M.

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

Immediate cause of death
Bladder. Metastasis
Due to Primary Reak. Unknown
Due to
Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 528
Of autopsy

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

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

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

S-41208