

V. S. No. 2
FORM-2-43
Revised 5-17-49
I X 35897

27462

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

ED AUG 27 1943

149

1002

Registrar's No. 3538

Registration District No. _____

Primary Registration District No. _____

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:
4260 E. 1162nd St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community 67 years (Specify whether 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. 4260 E. 1162 St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Mrs. Karolena A. Schmitter
3. (b) If veteran, name war No
3. (c) Social Security No. No

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Aug. day 14
year 1943 hour 12:20 minute P. M.

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced, widow
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Sept. 17-1852
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Aug. 9 1943, to Aug. 14 1943
that I last saw her alive on Aug. 14 1943
and that death occurred on the date and hour stated above.

8. AGE: Years 90 Months 10 Days 28 If less than one day _____
9. Birthplace Germany
(City, town, or county) (State or foreign country)

Immediate cause of death Senile Premia
Cystitis
Due to Old Age
Atherosclerosis
Due to Thrombophlebitis
Other conditions 131I
(Include pregnancy within 7 months of death)

10. Usual occupation at-home
11. Industry or business _____
12. Name of father John Tettlemay
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Untermaier
15. Birthplace Germany
(City, town, or county) (State or foreign country)

Major findings:
Of operations _____
Of autopsy _____

16. (a) Informant James F. Craighead
(b) Address 4260 E. 1162 St
17. (a) Burial (b) Date thereof 8/17/43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary R. C. Ch.
18. (a) Signature of funeral director Stone & McClure
(b) Address 3235 - Dickman Plaza
19. (a) 8-16-43 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

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 D. E. Brown (M. D. or other)
Address 80 - F. Foster Date signed 11/4/43

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

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

MOTHER FATHER

Dr. Geo. H. Jones
St. Louis, Mo.

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 E. M. Plank

Licensed Embalmer No. 1848

P. O. Address. 75. 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.