

ED SEP 7 1943  
Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3730

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:  
3125 Summit  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 45 years (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jackson **48**  
(c) City or town Kansas City **3**  
(If outside city or town limits, write "RURAL") **8**  
(d) Street No. 3125 Summit  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_ **0**

3. (a) PRINT FULL NAME JOHN SCHRANTZ  
3. (b) If veteran, name war No  
3. (c) Social Security No. 490-16-2480a

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 28th day August  
year 1943 hour \_\_\_\_\_ minute A M.

4. Sex Male 5. Color or race white  
6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Antonia Schrantz  
6. (c) Age of husband or wife if alive 56 years  
7. Birth date of deceased August 1 1870  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Aug 24  
1943 to Aug 28 1943  
that I last saw him alive on Aug 24 1943  
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>73</u>	<u>0</u>	<u>27</u>	hr. _____ min.

Immediate cause of death  
Carcinoma of bladder  
Due to \_\_\_\_\_  
Due to 528  
Other conditions (include pregnancy within 3 months of death)  
Major findings: Diagnosis verified by Cystoscopy  
Of autopsy \_\_\_\_\_

9. Birthplace Austria **4**  
(City, town, or county) (State or foreign country)  
10. Usual occupation Night Watchman

11. Industry or business \_\_\_\_\_  
MOTHER FATHER {  
12. Name Antoni Schrantz  
13. Birthplace Austria **4**  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary Lacheitz  
15. Birthplace Austria **4**  
(City, town, or county) (State or foreign country)

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 \_\_\_\_\_

16. (a) Informant Leonard Schrantz  
(b) Address 3125 Summit  
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 30 1943  
(Month) (Day) (Year)  
(c) Place: burial or cremation St. Marys Cemetery  
18. (a) Signature of funeral director Durk and Robin Co  
(b) Address 20 West Linwood  
19. (a) 8-28-43 (b) P. E. Brown  
(Date received local registrar) (Registrar's signature)

23. Signature P. J. O'Connell M.D. (M. D. or other) **9/28-43**  
Address 207 Uptown Bldg. Date signed  
K.C. Mo.

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

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**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.....  
*Harold Lee*

Licensed Embalmer No. *2810*

P. O. Address.....  
*H. E. Moore*

**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.**