

FILED OCT 23 1944

Registration District No. 72

Primary Registration District No. 1000

Registrar's No. 1032

1. PLACE OF DEATH:

(a) County Buchanan

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

(c) Name of hospital or institution State Hospital # 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 yrs 5 mo 27 days
(Specify whether years, months or days)

In this community in State Hosp # 2

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

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

(d) Street No. 514 Main
(If rural, give location)

(e) Citizen of foreign country? yes (Yes or No)
If yes, name country Germany

3. (a) PRINT FULL NAME Otto W. Schumann

3. (b) If veteran, name war Unk

3. (c) Social Security No. Unk

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 13 year 1944 hour 7 minute 25 P. M.

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 May 7 1875
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Sept 22 1944 to Oct 13 1944 that I last saw him alive on Oct 13 1944 and that death occurred on the date and hour stated above.

8. AGE: Years 69 Months 5 Days 9 If less than one day hr. min.

Immediate cause of death Various thrombi (Cerebral)

Due to varicose veins (phlebitis)

Due to Breaking down of tissues

Other conditions (include pregnancy within 3 months of death)

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

PHYSICIAN

Major findings: Of operations

Of autopsy fractured ribs - Strangled
hemmed - congested lungs

10. Usual occupation farmer

11. Industry or business farm

12. Name Carl Schumann

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

14. Maiden name Maria Kneidel

15. Birthplace Unknown (City, town, or county) Germany (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?

16. (a) Informant John Kead

(b) Address St. Joseph, Mo

17. (a) Bureau (b) Date thereof 10/17/44
(Month) (Day) (Year)

(c) State Hospital for Insane
(Place, bureau, or institution)

18. (a) Signature of funeral director Heaton, Drake & Bowman

(b) Address 319 So. 10th St.

19. (a) 10-17-44 (b) Allen J. Beckel
(Date received local registrar) (Registrar's signature)

While at work? (Specify type of place) (e) Means of injury

23. Signature L. S. Shuck (M. D. or other)
Address State Hosp for Insane Date signed 10/17/44

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

MOTHER FATHER

1377

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 not

....., Registered Apprentice No.....

working under my personal supervision.

Signed

Frank A. Brown

Licensed Embalmer No. 1710

P. O. Address St. Joseph

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Rev
Registrar's No. 1032

Registration District No. 42 Primary Registration District No. 1000

1. PLACE OF DEATH
(a) County Buchanan
(b) City or town St Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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 Otto W. Schumann
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 div
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May (Month) 4 (Day) 1904 (Year)

8. AGE: Years 69 Months 5 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct Day 13 Year 194 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____ 19____; that I last saw him _____ alive on _____ 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

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

Major findings: Fractured ribs 3 left 2 right ribs
Of operations: fractured femur
Of autopsy: fractured femur right side long standing

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Injury may have happened but not certain
(b) Day of occurrence Wed
(c) Where did injury occur? St. Joseph - Buchanan (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? In med at hospital in fight with
While at work? yes (Specify type of place) (e) Means of injury fall from patient's

23. Signature Lee J. Shuck (M. D. or other) Lee J. Shuck
Address St. Joseph Hospital #2 Date signed 10/13/44

SUPPLEMENTARY

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

MOTHER FATHER

Otto Schumann got
into fight with another
patient Sept 22 - 1944
on the ward O.J. 21
State Hospital #2

He sustained numerous
bruises & several broken
ribs.

He had about recovered
from injury & was up
& around ward & ready
for dismissal.

Died sitting in his chair
Oct 13 - 1944

J. J. Throckmold M.D.

10-31-44

3375A