

FILED JAN 4 1945  
Registration District No. **149**

Primary Registration District No. **1003**

Registrar's No. **5203**

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

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 Menorah Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 days  
(Specify whether years, months or days) 16 yrs

3. (a) PRINT FULL NAME

Al Schwartz

3. (b) If veteran, name war

no

3. (c) Social Security No.

no #

4. Sex M

5. Color or race wh

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

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive 25 years

7. Birth date of deceased April 25 1894

(Month) (Day) (Year)

8. AGE:

Years 50 Months 7 Days 24 If less than one day hr. min.

9. Birthplace New York City N.Y.

(City, town, or county) (State or foreign country)

10. Usual occupation Radio announcer

11. Industry or business

MOTHER FATHER

12. Name John Schwartz

13. Birthplace Ukraine Russia

14. Maiden name Chislov

15. Birthplace Russia

16. (a) Informant Al Schwartz

(b) Address Indianapolis Indiana

17. (a) burial (b) Date thereof Dec 21 '44

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rose Hill

18. (a) Signature of funeral director W. P. Laws Funeral Home

(b) Address 5400 Woodland

19. (a) 12-21-44 (b) D. E. Brown

(Date received local registrar) (Registrar's signature)

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. Courthouse Hotel  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country U

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 19  
year 1944 hour minute M.

21. I hereby certify that I attended the deceased from Dec. 15, 1944 to Dec. 19, 1944

that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death: Myocarditis  
Uremia Chronic  
Chronic Cornary disease  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Duration

Few  
years  
with  
febrile  
type

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, on farm, in industrial place, in public place?

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

23. Signature A. Soplun (M. D. or other)  
Address 1405 Bryant Date signed 12-21-44

**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.....

Licensed Embalmer No. ....

P. O. Address.....

**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.**