

FILED APR 23 1945  
1949

Registration District No. 1002

Primary Registration District No. 1002

4838  
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: Research Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 14 hours  
In this community 13 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Oscar F. Schuster

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

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

6. (b) Name of husband or wife Mrs. Emily Schuster 6. (c) Age of husband or wife if alive unknown years

7. Birth date of deceased. October 4 1888  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>56</u>	<u>6</u>	<u>2</u>	hr. min.

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

10. Usual occupation Bond Salesman

11. Industry or business X

MOTHER FATHER

12. Name Martin Schuster,

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

14. Maiden name unknown,

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

16. (a) Informant Mrs. Emily Schuster,  
(b) Address 3547 Agnes, Kansas City, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-10-45  
(Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill Cemetery  
Stine & McClure,

18. (a) Signature of funeral director Stine & McClure,  
(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 4-9-45 (Date received local Registrar) (b) Seraldine Holme (Registrar's signature)

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. 3547 Agnes  
(If rural, give location)  
(e) Citizen of foreign country? no. (Yes or No)  
If yes, name country X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 6th  
year 1945 hour minute P. M.

21. I hereby certify that I attended the deceased from 1945 to April 6 1945  
that I last saw him alive on April 6 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death: Acute Spontaneous Occlusion 5 hrs.  
Coronary Arteriosclerosis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other condition (Include precocity within 3 months of death): Had gout.

Major findings: None

Of operations: \_\_\_\_\_

Of autopsy: Same as above

Duration \_\_\_\_\_

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? \_\_\_\_\_ (Type of place)  
(c) Means of injury? \_\_\_\_\_ (M. D. or other)  
Saul Ferris M.D.  
Address 934 Maple St. Kansas City, Mo.  
April 17, 1945

*supple.*

Dr. Carl Ferris

**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 KC 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.