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ev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED SEP 1 1945

State File No. 26619

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3530

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: St Joseph Hosp'l
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 weeks (Specify whether In this community 15 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson 49

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 419 So Wheeling 8
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME ~~Johanna~~ Jeni Suscher ~~Luscher~~

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex F 1

5. Color or race W

6. (a) Single, widowed, married, divorced Married 1

6. (b) Name of husband or wife John

6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased 5 (Month) 7 (Day) 1899 (Year)

8. AGE: Years 46 Months 43 Days 14 If less than one day hr. min.

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

10. Usual occupation House wife

11. Industry or business Home

FATHER
12. Name Joseph Schaver
13. Birthplace (City, town, or county) Yugslovia (State or foreign country)

MOTHER
14. Maiden name Unk
15. Birthplace (City, town, or county) Unk (State or foreign country)

16. (a) Informant Mr John Luscher
(b) Address 419 So Wheeling

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 (Month) 24 (Day) 45 (Year)
(c) Place: burial or cremation St Marys

18. (a) Signature of funeral director J P Shea
(b) Address Kansas City Mo

19. (a) 8-23-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 21 year 1945 hour 11 minute 15 P.M.

21. I hereby certify that I attended the deceased from 8-14-45, 1945, to 8-22, 1945, that I last saw her alive on 8-21-45, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Intestinal obstruction	
Due to adhesions	
Due to Extreme Toxicity	
Other conditions Myocardial Weakness (Include pregnancy within 3 months of death)	2

Major findings: Of operations adhesion and abstructed bowel 12-2-45

Of autopsy none

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature [illegible] (M. D. or other)

Address Argyle Bldg Date signed 8-22-45

(Licensed Embalmer's Statement on Reverse Side)

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 John P. S. Keil

Licensed Embalmer No. 3625

P. O. Address K. 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.