S. No. 2
—9-4-41
5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 22 1945

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30365

Registration District No. 72 Primary Registration District No. 3613 Registrar's No. 77

1. PLACE OF DEATH:

(a) County Clay
(b) City or town North Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2014 Erie st - Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 yrs (Specify whether
In this community 10 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Clay 24
(c) City or town North Kansas City 2
(If outside city or town limits, write "RURAL")
(d) Street No. 2014 Erie 1
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Fannie Carr Schoolfield
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F
5. Color or race Wht
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Sept (Month) 18 (Day) 1874 (Year)

8. AGE:	Years	Months	Days	If less than one day
	70	11	20	hr. min.

9. Birthplace Clay Co (City, town, or county) Mo (State or foreign country)
10. Usual occupation H.W.
11. Industry or business
FATHER
12. Name T J Schoolfield
13. Birthplace (City, town, or county) Mo (State or foreign country)
MOTHER
14. Maiden name Mollie R. Crossett
15. Birthplace (City, town, or county) Mo (State or foreign country)
16. (a) Informant Mrs Grace Mason
(b) Address 2014 Erie North Kansas City
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 - 10 - 45 (Month) (Day) (Year)
(c) Place: burial or cremation Bethel Cem
18. (a) Signature of funeral director Morton Funeral Home
(b) Address North Kansas City Mo
19. (a) Sept 10th 1945 (Date received local registrar) (b) Beulah Kitchen (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 8
year 1945 hour 11 minute A.M.
21. I hereby certify that I attended the deceased from 4-19-45, 19 to death, 19
that I last saw her alive on 9/8/45, 19
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Carcinoma of ~~Stom~~ Sigmoid Colon	1-2 yrs
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations 46	
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?
(Specify type of place)
While at work? (e) Means of injury
23. Signature R. H. Dunbar M.D. (M.D. or other)
Address North KC, Mo Date signed 9/8/45

1411

(Licensed Embalmer's Statement on Reverse Side)

FEB 7 1943

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. 4349

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.