

S. No. 2
M-5-43
r. 5-17-39
p I X36671

FILED NOV 7 1945
Registration District No. **1002**

Primary Registration District No. **1002**

Registrar's No. **4388**

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 St Marys Hospital 0
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution Ten Days
 (Specify whether years, months or days) 16 Years

3. (a) PRINT FULL NAME Rev. Constantine SCHAAF
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 SINGLE
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased May 26th, 1876
 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
69	4	28	hr. min.

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

10. Usual occupation Minister
Catholic Priest

11. Industry or business
12. Name Oswald Schaaf
13. Birthplace Germany
 (City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Germany
 (City, town, or county) (State or foreign country)

16. (a) Informant Father Patrick McIrwin
(b) Address 2552 Locust, K.C. Mo.

17. (a) Burial **(b) Date thereof** 10/27/45.
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Marys Cemetery
Mallady-McGilley-Eyler

18. (a) Signature of funeral director 1800 Linwood, Kansas City, Mo.
(b) Address

19. (a) 10/25/45. **(b)** Theraldine Holmes
 (Date received local registrar) (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. 2552 Locust
 (If rural, give location)
 (e) Citizen of foreign country? No. (Yes or No)
 If yes, name country

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month October day 24
 year 1945 hour 2:45 minute 11 A. M.
21. I hereby certify that I attended the deceased from October 14
 1945 to October 24, 1945
 that I last saw him alive on October 23, 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death
Acute Circulatory Failure
 Due to Subtotal Abstraction
 Due to Acute Coronary Artery Disease
 of Anginal
 Other conditions 4/6/2
 (Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings: distention of proximal colon
 Of operations: Distension of proximal colon
 Of autopsy: see above cause of death
 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 E. C. ... (M. D. or other)
Address 1002 Apple Bldg **Date signed** 10.24.45

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.