

S. No. 2
M-5-43
v. 5-17-39
X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36378

State File No. _____

Registrar's No. 4765

FILED DEC 6 1945
Registration District No. 149

Primary Registration District No. 1002

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:
Little Sisters of the Poor
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 mo. 11 days
78 years (Specify whether years, months or days)

In this community _____

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. 4550 Millcreek Parkway
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME FRANK F. SCHMIDT

3. (b) If veteran, name war No

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 19th
year 1945 hour 2: minute 30 P. M.

4. Sex Ma

5. Color or race Wh

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

6. (b) Name of husband or wife Mollie L. Schmidt

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

7. Birth date of deceased September 8 1855
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov. 1
1945 to Nov. 19 1945
that I last saw her alive on Nov. 18 1945
and that death occurred on the date and hour stated above.

8. AGE: Years 90 Months 2 Days 11
If less than one day, _____ hr. _____ min.

Immediate cause of death Bronchial pneumonia Duration 3 days

Due to arteriosclerosis year

Due to myocardiosis year

Other conditions _____
(Include pregnancy within 3 months of death)

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

10. Usual occupation Retired-Confectionary

Major findings: no

Of operations _____

Of autopsy no

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

11. Industry or business _____

12. Name Frank Schmidt

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

14. Maiden name Elizabeth Schleichner
(City, town, or county) (State or foreign country)

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

16. (a) Informant Edwin B. Schmidt

(b) Address 3517 Main St.

17. (a) Bunial (b) Date thereof 11-21-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington

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? _____

18. (a) Signature of funeral director J. W. Wagner

(b) Address Kansas City, Mo.

19. (a) 11-20-45 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

(c) Means of injury _____

23. Signature John T. Blanner (M. D. or other) MP

Address 1105 Grand Ave Date signed 11-20-45

(Licensed Embalmer's Statement on Reverse Side)

J. E. M. D.

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 Alvin R. Harnschild

Licensed Embalmer No. #159

P. O. Address Kansas City

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.