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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6267

State File No.

539

FILED FEB 18 1953

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) Independence 7005	
c. LENGTH OF STAY (In this place) 1 wk		d. STREET ADDRESS (If rural, give location) 415 W. Truman Rd. X	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Lukes Hospital			

3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
a. (First) Andrew	b. (Middle) H.	c. (Last) Schmidt or	(Month) (Day) (Year) 1 27 1953

5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH May 5, 1868	9. AGE (In years last birthday) 84	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dairyman	10b. KIND OF BUSINESS OR INDUSTRY self employed	11. BIRTHPLACE (State or foreign country) Andrarum, Sweden 4	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Hakaman Olson	13b. MOTHER'S MAIDEN NAME Hanna Nilson	14. NAME OF HUSBAND OR WIFE unknown
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Mrs. Blanche Hylton, Independence, Mo	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 4200
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic heart disease with cardiac failure		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) Chronic pulmonary infection and fibrosis Polycythemia		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 1951, to Jan 27, 1953, that I last saw the deceased alive on Jan 26, 1953, and that death occurred at 3:45 Am., from the causes and on the date stated above.

23a. SIGNATURE W.N. Beachy MD	(Degree or title)	23b. ADDRESS K.C., Mo. H.D. 5749 Kenwood	23c. DATE SIGNED 1-27-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Jan 30, 53	24c. NAME OF CEMETERY OR CREMATORY Md. Grove Cem.	24d. LOCATION (City, town, or county) (State) Independence, Mo.
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DATE REC'D BY LOCAL REG. 1-27-53	REGISTRAR'S SIGNATURE Heraldine Smith	25. FUNERAL DIRECTOR'S SIGNATURE F. Johnson	ADDRESS Independence, Mo
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(Licensed Embalmer's Statement on Reverse Side)

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

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificaté was embalmed by me, or by.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed *Charles E. Schroeder*.....

Licensed Embalmer No. *4741*.....

P. O. Address *Independence, 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.