

FILED MAY 17 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **16151**

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>1917</u>			
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>Kansas</u>				b. COUNTY <u>Johnson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Kan City Mo.</u>		c. LENGTH OF STAY (In this place) <u>17 days</u>		c. CITY OR TOWN <u>Missouri</u>		d. Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Joseph's Hosp.</u>				e. STREET ADDRESS (If rural, give location) <u>5628 Russell</u>				815 <sup>th</sup> 8	
3. NAME OF DECEASED (Type or Print)		a. (First) <u>FRED</u>		b. (Middle) <u>M</u>		c. (Last) <u>SCHROEDER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>4/28/54</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED 1</u>		8. DATE OF BIRTH <u>10-17-85</u>		9. AGE (In years last birthday) <u>68</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or as if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Paola Kansas</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13a. FATHER'S NAME <u>Henry Schroeder</u>			13b. MOTHER'S MAIDEN NAME <u>Hensietta Baugel</u>			14. NAME OF HUSBAND OR WIFE <u>Dora Schroeder</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Hospital Records</u>					ADDRESS
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cirrhosis of the Liver</u>						58 <sup>hr</sup>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Congestive Heart Failure</u>							
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) (Min)		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 <u>4/17</u> , 19 <u>54</u> , to <u>4/27</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>4/27</u> , 19 <u>54</u> , and that death occurred at <u>1:55 P.M.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>Leo F. Cooper</u> (Degree or title) <u>Leo F. Cooper, M.D.</u>				23b. ADDRESS <u>St. Joseph's Hospital K.C. Mo.</u>			23c. DATE SIGNED <u>4/28/54</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		24b. DATE <u>4/28/54</u>		24c. NAME OF CEMETERY OR CREMATOR <u>Paola Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>Paola, Kansas</u>			
DATE REC'D BY LOCAL REG. <u>4-28-54</u>		REGISTRAR'S SIGNATURE <u>Geraldine Smith</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>Wilson &amp; Son</u>				ADDRESS <u>Paola, Kansas</u>

(Licensed Embalmer's Statement on Reverse Side)

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

*Remains to Pauly Kom*  
*Remains for Embalming*

**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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....  
*Chas. R. Miller*

Licensed Embalmer No. <sup>Kans.</sup> 212

P. O. Address *Pauly Kom*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.