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FILED AUG 18 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **27196**
Registrar's No. **3566**

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>KANSAS CITY</u>		c. CITY OR TOWN <u>KANSAS CITY</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>23Yrs</u>		f. STREET ADDRESS (If rural, give location) <u>1011 No Monroe</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>XRESTWOODS Hosp</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>REMI</u> b. (Middle) _____ c. (Last) <u>DESCHAPPER</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>JULY - 21 1954</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>9/29/1890</u>	9. AGE (In years last birthday) <u>63</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Punch Press Op.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unemp.</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Belgium</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>

13a. FATHER'S NAME <u>Augustus De Schepper</u>	13b. MOTHER'S MAIDEN NAME <u>Emily Van Maley</u>	14. NAME OF HUSBAND OR WIFE <u>Magdelene De Yonker De Schepper</u>
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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) <u>not Yes W.W. # I</u>	16. SOCIAL SECURITY NO. <u>492-18-6605</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Magdelene De Schepper, 1011 No Monroe</u>
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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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Terminal bronchopneumonia</u>		<u>3 days</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Parkinson's disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u>		<u>6 yrs</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Recent subtotal gastric resection for ulcer in 1951</u>			<u>indet.</u>

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) <u>Kansas City Jackson Co. Mo.</u>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	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 7-19, 1954 to 7-21, 1954, that I last saw the deceased alive on 7-20, 1954, and that death occurred at 4:45A.M., from the causes and on the date stated above.

23a. SIGNATURE <u>Wilson H. Miller, M.D.</u> (Degree or title)	23b. ADDRESS <u>4620 Indep. Ave. K.C. Mo.</u>	23c. DATE SIGNED <u>7-21-54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>7/22/54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>	24d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>7-22-54</u>	REGISTRAR'S SIGNATURE <u>Geraldine Smith</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>John P. Sheil, K.C. Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
Wilson H. Miller MD

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 *John P. Hall*.....

Licensed Embalmer No. 36

P. O. Address H. C. H.

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.