

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17343

FILED JUN 12 1957

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registor's No. 2443

| | | | | | | | | |
|---|-------------------------------|---|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY JACKSON | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY JACKSON | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN KANSAS CITY | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION CHILDREN'S MERCY HOSP 1345 | | | Length of stay in <input type="checkbox"/> 15 <input type="checkbox"/> 30 <input type="checkbox"/> 45 <input type="checkbox"/> 60 <input type="checkbox"/> 90 <input type="checkbox"/> 120 <input type="checkbox"/> 180 <input type="checkbox"/> 270 <input type="checkbox"/> 360 <input type="checkbox"/> 540 <input type="checkbox"/> 720 <input type="checkbox"/> 900 <input type="checkbox"/> 1080 <input type="checkbox"/> 1440 <input type="checkbox"/> 1800 <input type="checkbox"/> 2160 <input type="checkbox"/> 2700 <input type="checkbox"/> 3240 <input type="checkbox"/> 3780 <input type="checkbox"/> 4320 <input type="checkbox"/> 4860 <input type="checkbox"/> 5400 <input type="checkbox"/> 5940 <input type="checkbox"/> 6480 <input type="checkbox"/> 7020 <input type="checkbox"/> 7560 <input type="checkbox"/> 8100 <input type="checkbox"/> 8640 <input type="checkbox"/> 9180 <input type="checkbox"/> 9720 <input type="checkbox"/> 10260 <input type="checkbox"/> 10800 <input type="checkbox"/> 11340 <input type="checkbox"/> 11880 <input type="checkbox"/> 12420 <input type="checkbox"/> 12960 <input type="checkbox"/> 13500 <input type="checkbox"/> 14040 <input type="checkbox"/> 14580 <input type="checkbox"/> 15120 <input type="checkbox"/> 15660 <input type="checkbox"/> 16200 <input type="checkbox"/> 16740 <input type="checkbox"/> 17280 <input type="checkbox"/> 17820 <input type="checkbox"/> 18360 <input type="checkbox"/> 18900 <input type="checkbox"/> 19440 <input type="checkbox"/> 20000 | | d. STREET ADDRESS 3423 MORRELL | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) WILLIAM FRANCIS SCHOLLARS | | | First Middle Last | | 4. DATE OF DEATH Month Day Year 5-24-1957 | | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 2-13-1944 | | 9. AGE (In years last birthday) 13 | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHILD | | 10b. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (City and state or country) KANSAS CITY, MO | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME ARON J. SCHOLLARS | | | | 14. MOTHER'S MAIDEN NAME GERTRUDE RENNER | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT ARON J. SCHOLLARS KCMO | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) perforation anterior wall of stomach Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Hodgkin's Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 20 1/2 | | |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m. | | | | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION | | | COUNTY STATE | |
| 21. I attended the deceased from 5-23-1957 to 5-24-1957 and last saw her alive on 5-24-1957 Death occurred at 5:24-1957 5:45 A.M. on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE Wayne Hart M.D. (Degree or title) | | | | 22b. ADDRESS 1710 9th Ave KCMO | | 22c. DATE SIGNED 5-24-57 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 5-27-1957 | 23c. NAME OF CEMETERY OR CREMATORY ST. MARY'S CEM | | 23d. LOCATION (City, town, or county) (State) KANSAS CITY, MO | | | |
| 24. FUNERAL DIRECTOR VASSANTINO BROS KCMO | | | ADDRESS | | 25. DATE REC'D. BY LOCAL REG. 5-25-57 | | 26. REGISTRAR'S SIGNATURE Neva Minshall | |



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 *Ronald Ross*.....

Licensed Embalmer No. *45*.....

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

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