

Health,  
& Welfare  
S. Public  
Health Service

FILED JAN 8 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

44585  
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5847

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>KANSAS CITY</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>6128 FOREST AVE</b>		Length of stay in 1b <b>4 YEARS</b>	d. STREET ADDRESS (If outside, give location) <b>6128 FOREST AVENUE</b>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <b>ELLA</b> Middle <b>MARGARET</b> Last <b>SCHMITT</b>			4. DATE OF DEATH Month <b>DEC.</b> Day <b>10</b> Year <b>1957</b>		
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5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL-13-1886</b>	9. AGE (In years last birthday) <b>71</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>	10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (City and state or country) <b>McKITTRICK, MO.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>MARTIN V. HART</b>	13b. MOTHER'S MAIDEN NAME <b>JOSEPHINE CRASS</b>	14. NAME OF HUSBAND OR WIFE <b>LORENZA A. SCHMITT</b>
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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) <b>NO</b>	16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT <b>CELESTINE M. SCHMITT</b>	Address <b>6128 FOREST AVENUE KANSAS CITY, MO.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4201</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Sustained Insufflation</b>		19. WAS AUTOPSY PERFORMED? <b>2</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	
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20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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
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21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her alive on \_\_\_\_\_  
Death occurred at **11:40 P.** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Hugh H. Owens</b>	22b. ADDRESS <b>1034 Walnut Blvd</b>	22c. DATE SIGNED <b>12-11-57</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>12-11-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. BONIFACE CEMETERY</b>	23d. LOCATION (City, town or County) (State) <b>BRUNSWICK MISSOURI</b>
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24. FUNERAL DIRECTOR <b>D.W. Newcomer's Sons</b>	ADDRESS <b>KANSAS CITY, MO.</b>	25. DATE RECD. BY LOCAL REG. <b>12-11-57</b>	26. REGISTRAR'S SIGNATURE <b>Neve Marshall</b>
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(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

Hugh H. Owens



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 *Vern Lawler* .....

Licensed Embalmer No. *4915* .....

P. O. Address *47 E 32. Hill* .....

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.