

IRI DIVISION - OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032561

FILED VS. OCT. 7 1959 / 49

Registration District No. 1002 Primary Registration District No. 1002 Registrar's No. 4590 STATE FILE NUMBER

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, give TOWNSHIP only) <u>Kansas City</u>		Length of stay in 1b <u>60 yrs.</u>		c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Lukes Hosp.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>5024 Garfield Ave.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Fredrick</u> Last <u>Schaefer</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>19</u> Year <u>1959</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>4-5-91</u>		9. AGE (last birthday) <u>68</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>T. SCHAEFER DISTRIBUTING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ALL S CHALMERS DIV TRANSFORMER</u>		11. BIRTHPLACE (City and state or country) <u>PLATTSMOUTH NEB.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>					
13a. FATHER'S NAME <u>JOHN F. SCHAEFER</u>			13b. MOTHER'S MAIDEN NAME <u>NATHALIE VANDER VELDE</u>			14. NAME OF HUSBAND OR WIFE <u>HELEN SCHAEFER</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WWI</u>			16. SOCIAL SECURITY NO. <u>500 38 3921</u>		17. INFORMANT <u>MARTHA SBHAEFER 6035 HIGH DRIVE</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Art. Act Heart Disease</u>								INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>			
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) <u>Pulmonary Siderodysplasia - Polyphonia</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		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 _____ a.m. _____ p.m. Month, Day, Year _____		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 <u>1 Oct 1949</u> to <u>19 Sept 1959</u> and last saw her/him alive on <u>11 Sept 1959</u> Death occurred at <u>5:40 P.</u> on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) <u>Blaine Z. Hibbard</u>						22b. ADDRESS <u>411 Nichols K.C. Mo</u>			22c. DATE SIGNED <u>20 Sept 59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>SEPT 22, 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FOREST HILL CEM</u>			23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY, MO.</u>				
24. FUNERAL DIRECTOR <u>D.W. Newcomers Sons Kansas City, Mo.</u>						25. DATE RECD. BY LOCAL REG. <u>9-21-59</u>		26. REGISTRAR'S SIGNATURE, <u>Neve Marshall</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Blaine Z. Hibbard

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Thomas W. Johnson

Licensed Embalmer No. 4889

P. O. Address A. C. No

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.