

R DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-001872

FILED VS FEB 4 1960

Registration District No. 189 Primary Registration District No. 1002 Registrar's No. 495 STATE FILE NUMBER

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>		Length of stay in 1b <b>94 yrs.</b>		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>LOCARNO APT 235 Ward Pharmacy</b>				d. STREET ADDRESS (If outside, give location) <b>LOCARNO APT 235 Ward Pharmacy</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>FRANCES TOBENER SCHOEN</b>				4. DATE OF DEATH Month Day Year <b>JAN 26, 1960</b>			
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>DEC 13, 1864</b> 95 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>EAST ST. LOUIS</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>HENRY TOBENER</b>			13b. MOTHER'S MAIDEN NAME <b>ELIZABETH</b>			14. NAME OF HUSBAND OR WIFE <b>GEORGE SCHOEN</b>	
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>NO</b>		17. INFORMANT Address <b>WILBUR COEN WORNALL PLAZA</b>			
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>CARCINOMA OF ESOPHAGUS</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 mos.</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>ARTERIO SCLEROTIC HEART DISEASE</b>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 s.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 <b>1948</b> to <b>Jan 26, 1960</b> and last saw her <b>Jan 25, 1960</b> alive on <b>Jan 25, 1960</b> Death occurred at <b>5:00 A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Lucile M. Kohn, M.D.</b>				22b. ADDRESS <b>751-2-63</b>		22c. DATE SIGNED <b>1-26-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>1 28 60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ELMWOOD CEM</b>		23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY MO.</b>		
24. FUNERAL DIRECTOR ADDRESS <b>D. W. NEWCOMER'S SONS K. C. MO.</b>				25. DATE RECD. BY LOCAL REG. <b>1-27-60</b>		26. REGISTRAR'S SIGNATURE <b>Debra Marshall</b>	

DOCUMENT

MEDICAL CERTIFICATION  
Cecil M. Kohn

BY AFFIDAVIT OF

**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 Albert H. Savage

Licensed Embalmer No. 4813

P.O. Address Hansboro

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.