

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-015768

FILED VS APR 19 1960

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 214

STATE FILE NUMBER

UNRECORDED

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) OR TOWN <u>INDEPENDENCE</u> Length of stay in lb <u>2 months</u>		c. CITY OR TOWN <u>BLUE SPRINGS</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>KIRBY REST HOME</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>408. Box 56 RR # 2</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELMER J SCHWARTZ</u>			4. DATE OF DEATH Month Day Year <u>4 12 60</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WH.</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 29-90</u>
9. AGE (last birthday) <u>65</u>		IF UNDER 1 YEAR Months Days <u>5 13</u>	IF UNDER 24 HR Hours Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PAPER Co</u>	11. BIRTHPLACE (City and state or country) <u>BELLVILLE ILL. U S</u>
12. CITIZEN OF WHAT COUNTRY <u>U S</u>		13a. FATHER'S NAME <u>JOSEPH SCHWARTZ</u>	
13b. MOTHER'S MAIDEN NAME <u>CAROLINE Kochman</u>		14. NAME OF HUSBAND OR WIFE <u>RUTH L. SCHWARTZ</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes World War II</u>		16. SOCIAL SECURITY NO. <u>495-05-1209</u>	17. INFORMANT <u>Mrs Ruth Schwartz</u> Address <u>Blue Springs</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>Carcinoma of urinary bladder</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>June 1959</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			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 type="checkbox"/> NO <input checked="" 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 Month, Day, Year <u>8 p.m.</u>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>12/5/59</u> to <u>4/12/60</u> and last saw him alive on <u>4/12/60</u> Death occurred at <u>10 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Osbert M.D.</u>		22b. ADDRESS <u>808 So 10 Blue Springs Mo</u>	22c. DATE SIGNED <u>4/13/60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removed</u>	23b. DATE <u>4-14-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ozark Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Ozark Mo</u>
24. FUNERAL DIRECTOR <u>Mayfield Blue Springs</u>		25. DATE RECD. BY LOCAL REG. <u>4-14-60</u>	26. REGISTRAR'S SIGNATURE <u>James J. [Signature]</u>

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Charles E. Mayfield
Licensed Embalmer No. 4638

P. O. Address Blue Spring

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.