SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

TMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2201 -61-017757 STATE FILE NUMBER

AMENDED

FILED MAY 19 1961

DATE AMENDED

INSTEAD OF

DOCUMENT

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY JACKSON
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY — Length of stay in 1b 82 YEARS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. MARY'S HOSPITAL — Inside Limits Yes X No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY JACKSON
c. CITY OR TOWN KANSAS CITY — Inside Limits Yes X No ☐
d. STREET ADDRESS (If outside, give location) 5700 BALES AVENUE — Reside on Farm Yes ☐ No X

3. NAME OF DECEASED (Type or print) First WALTER Middle LEWIS Last SCHAFFER
4. DATE OF DEATH Month MAY Day 2 Year 1961
5. SEX MALE
6. COLOR OR RACE WHITE
7. Married X Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH NOV 21, 1875
9. AGE (last birthday) 85 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FEDERAL RESERVE BANK
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) WARRENSBURG, MO.
12. CITIZEN OF WHAT COUNTRY U. S. A.
13a. FATHER'S NAME CHARLES SCHAFFER
13b. MOTHER'S MAIDEN NAME UNKNOWN
14. NAME OF HUSBAND/OR WIFE MRS. JOSIE SCHAFFER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) ---
16. SOCIAL SECURITY NO.
17. INFORMANT MRS. JOSIE SCHAFFER Address 5700 BALES AVE. KANSAS CITY, MO.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia Bilateral — INTERVAL BETWEEN ONSET AND DEATH
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) Generalized arteriosclerosis with cerebrovascular insufficiency
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO X
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 4/13/61, to 5/2/61 and last saw her/him alive on 5/2/61
Death occurred at 7:35 A.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE H. Allen Underwood (Degree or title) M.D.
22b. ADDRESS 5100 E 24th K.C. MO
22c. DATE SIGNED 5/2/61

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE MAY 4, 1961
23c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY
23d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI

24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS ADDRESS 1331 BRUSH CREEK KANSAS CITY, MO.
25. DATE RECD. BY LOCAL REG. 5-4-61
26. REGISTRAR'S SIGNATURE Ruth Long

(Licensed Embalmer's Statement on Reverse Side)

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_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No. 1998

P. O. Address_____

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.