

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

= 62-011335

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1405

FILED MAR 28 1962

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Rev. 4/59

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <b>Jackson</b>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR <b>Kansas City</b>		a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>		c. CITY OR TOWN <b>Kansas City</b>	
Length of stay in 1b <b>47yrs</b>		c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Menorah Medical Center</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>4111 East 107th Street</b>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		3. NAME OF DECEASED (Type or print) First <b>Suzanna</b> Middle <b>Magdalene</b> Last <b>Schultz</b>		4. DATE OF DEATH Month <b>3</b> Day <b>7</b> Year <b>62</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>8-21-1889</b>	9. AGE (last birthday) <b>72</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	IF UNDER 24 HR Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Church Rectory</b>		11. BIRTHPLACE (City and state or country) <b>Hungary</b>		12. CITIZEN OF WHAT COUNTRY <b>—</b>	
13a. FATHER'S NAME <b>John Berenz</b>			13b. MOTHER'S MAIDEN NAME <b>Elizabeth (unknown)</b>			14. NAME OF HUSBAND OR WIFE <b>Adolph L. Schultz</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Marie Shurmantine</b>		Address <b>Home</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b>							<b>5 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							
DUE TO (b) <b>mitral stenosis</b>							<b>10yrs</b>
DUE TO (c) <b>Rheumatic Fever</b>							<b>?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>o destructive of auricle - stone @ ampulla Vals</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 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 _____ Month, Day, Year _____ a.m. _____ p.m. _____		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>12-30-62</b> to <b>3-7-62</b> and last saw her alive on <b>3-7-62</b> Death occurred at <b>7:03</b> <b>P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Bruce R. Buie M.D.</b>				22b. ADDRESS <b>5801 Hingalee K.C. 34 Mo</b>		22c. DATE SIGNED <b>3-9-62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>3-10-1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City Missouri</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Melody-McGillie-Eylar 20 W. Linwood K.C. 11, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>3-9-62</b>		26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>	

USE BLACK INK OR TYPEWRITER RIBBON

2019-2020

**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 Wm H. Lentz

Licensed Embalmer No. 5038

P. O. Address K. C. Mo.

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.