

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-011906

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1898

DO NOT WRITE ON THIS STUB

AMENDED

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Rev. 4/59

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| FILED APR 4 1963 | | | | | | | |
| <p>1. PLACE OF DEATH</p> <p>a. COUNTY JACKSON</p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY Length of stay in 1b 43 YEARS</p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LUKES HOSPITAL Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> | <p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE MISSOURI b. COUNTY JACKSON</p> <p>c. CITY OR TOWN KANSAS CITY Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) 11206 BANNISTER RD. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> | | | | | | |
| <p>3. NAME OF DECEASED First HANS Middle — Last SCHAERRER</p> | | | | | | | |
| <p>4. DATE OF DEATH Month MARCH Day 23 Year 1963</p> | | | | | | | |
| <p>5. SEX MALE</p> | <p>6. COLOR OR RACE WHITE</p> | <p>7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p> | <p>8. DATE OF BIRTH 10-28-1886</p> | <p>9. AGE (last birthday) 76 YEARS</p> | <p>IF UNDER 1 YEAR Months Days</p> | <p>IF UNDER 24 HR Hours Min.</p> | |
| <p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) medical doctor</p> | | <p>10b. KIND OF BUSINESS OR INDUSTRY Medicine</p> | | <p>11. BIRTHPLACE (City and state or country) SWITZERLAND</p> | | <p>12. CITIZEN OF WHAT COUNTRY USA</p> | |
| <p>13a. FATHER'S NAME HANS SCHAERRER, SR.</p> | | | <p>13b. MOTHER'S MAIDEN NAME UNKNOWN</p> | | <p>14. NAME OF HUSBAND OR WIFE MARIE SCHAERRER</p> | | |
| <p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES WW #1 & WW #2</p> | | <p>16. SOCIAL SECURITY NO. —</p> | | <p>17. INFORMANT Address Dr. Wm. C. Schaerrer, 5245 Mercier, K.C. Mo</p> | | | |
| <p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:</p> <p style="text-align: center;">IMMEDIATE CAUSE (a) Bronchopneumonia Bilateral</p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I: (a) Arteriosclerotic Heart Disease</p> <p>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</p> | | | | | | <p>INTERVAL BETWEEN ONSET AND DEATH 3 days</p> | |
| <p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></p> | | <p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p> | | <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p> | | | |
| <p>20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year</p> | | <p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p> | | <p>20e. PLACE OF INJURY. (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> | | <p>20f. CITY, TOWN, OR LOCATION COUNTY STATE</p> | |
| <p>21. I attended the deceased from <u>May 1956</u> to <u>March 23, 1963</u> and last saw him alive on <u>3/23/63</u> Death occurred at <u>5:10 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.</p> | | | | | | | |
| <p>22a. SIGNATURE (Degree or title) Robert W. Hamill MD</p> | | | <p>22b. ADDRESS 4320 Cornell Kansas City Mo</p> | | <p>22c. DATE SIGNED 3/25/63</p> | | |
| <p>23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION</p> | | <p>23b. DATE MARCH 25, 1963</p> | | <p>23c. NAME OF CEMETERY OR CREMATORY ELMWOOD CEMETERY</p> | | <p>23d. LOCATION (City, town, or county) (State) KANSAS CITY, MISSOURI</p> | |
| <p>24. FUNERAL DIRECTOR ADDRESS MUEHLEBACH FUNERAL HOME, 6800 TROOST AV.</p> | | | <p>25. DATE RECD. BY LOCAL REG. 3-25-63</p> | | <p>26. REGISTRAR'S SIGNATURE <i>Ruth Song</i></p> | | |

USE BLACK INK OR TYPEWRITER RIBBON

ROBERT W. HAMILL - MEDICAL CERTIFICATION

DR R. H. Hamill
4330 Wornell Rd
JFK 1-2020
p. 0

MAR 13 1967

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 Robert G. Landes

Licensed Embalmer No. 5103

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.