

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH.

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB
 AMENDED

Registration District No. 149 Primary Registration District No. 002 Registrar's No. 3556 ~~158-00-1585~~

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DATE AMENDED
 ITEM NO. SHOULD READ
 BY AFFIDAVIT OF

1	2700X
3	
4	0
5	0
6	
7	0
8	0
9	9750X
10	
11	
12	64-0
13	

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City		Length of stay in 1b 1 day	c. CITY OR TOWN Raytown Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) Research Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 6112 Arlington Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) William Edward Schulz			4. DATE OF DEATH Month June Day 23 Year 1963
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-22-1963
9. AGE (last birthday) 1 day		IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	IF UNDER 24 HR. Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Kansas City, Mo
12. CITIZEN OF WHAT COUNTRY USA		13. NAME OF HUSBAND OR WIFE None	
13a. FATHER'S NAME William E. Schulz		13b. MOTHER'S MAIDEN NAME Dorothy J. George	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		15. SOCIAL SECURITY NO. [Redacted]	
16. INFORMANT William E. Schulz, 6112 Arlington		Address Raytown, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO (b) Myocardial infarction DUE TO (c) Congenital aortic			INTERVAL BETWEEN ONSET AND DEATH 18 hrs
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 [Blank] Month, Day, Year [Blank] a.m. p.m.		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 6-22-63 to 6-23-63 and last saw her/him alive on 6-23-63 . Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE [Signature] (Degree title)		22b. ADDRESS 7721 State Ave	
22c. DATE SIGNED 6-25-63			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6-25-1963	23c. NAME OF CEMETERY OR CREMATORY Floral Hills	
23d. LOCATION (City, town, or county) Kansas City, Missouri		(State)	
24. FUNERAL DIRECTOR ADDRESS Floral Hills Funeral Home, Kansas City, Missouri		25. DATE RECD. BY LOCAL REG. 6-25-63	26. REGISTRAR'S SIGNATURE [Signature]

USE BLACK INK OR TYPEWRITER RIBBON

DR Richard H. McLaughlin
772 State St.
Sm 1-5208
DR at Research
772 State St.
Sm 1-5208

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 *C. M. James*

Licensed Embalmer No. 3453

P. O. Address H. C. Kane

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.