24 1920

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

21128

1. PLACE OF DEATH
County Lawrence — Registration District No. 470 — File No. 290
Township Mt V — Primary Registration District No. 5633 — Registered No.
City ..... (No. ..... St. ..... Ward)

2. FULL NAME Frank Schanda
(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 1 yrs. — mos. — ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: X

6. DATE OF BIRTH (MONTH, DAY AND YEAR): April 14 - 1901

7. AGE: Years 27 — Months 1 — Days 17 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): X
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Bohemia

PARENTS
10. NAME OF FATHER: Anton Schanda
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Bohemia
12. MAIDEN NAME OF MOTHER: Annie Lorenz
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Bohemia

14. INFORMANT: Anton Schanda
(Address): Cascade Mo. Wayne Co.

15. FILED July 29, 1928 W I Fulton, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): June 1st 1928

17. I HEREBY CERTIFY, That I attended deceased from Dec 25, 1927, to June 1, 1928 that I last saw him alive on June 1, 1928, and that death occurred, on the date stated above, at 6.30 PM m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Potts Disease Tuberculosis of the Spine
(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (SECONDARY): Pulmonary Tuberculosis
(duration) ? yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? ?
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? X ray & Cultures
(Signed) Byron J. McGinnis, M. D.
, 19 (Address) Mo State Sanatorium

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Sanatorium Cemetary — DATE OF BURIAL: 6/4 1928

20. UNDERTAKER: Geo B Orr — ADDRESS: Mt V

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.