

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

Do not use this space.

28731

**1. PLACE OF DEATH**

County.....

Registration District No.....

791

Township.....

Primary Registration District No.....

1003

City.....

No. 5449 Reber Place

File No.....

Registered No. 8193

St..... Ward.....

**2. FULL NAME**

Frank Schaff

(a) Residence No..... St. 13 Ward.....

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 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) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Elizabeth Schaff

6. DATE OF BIRTH (MONTH, DAY AND YEAR) See 19-11-63

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
64 8 22

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

10. NAME OF FATHER Wm Schaff

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER Annie Diehl

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Germany

14. INFORMANT Mrs Elizabeth Schaff (Address) 449 Reber Place

15. FILED 116 13 1955 Max C Stanley REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 11 1928

17. I HEREBY CERTIFY That I attended deceased from Dec 10 1928 to Aug 10 1928, and that that I last saw him alive on Aug 10 1928, and that death occurred, on the date stated above, at 10:20 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Bronchial Asthma  
non Tubercular

CONTRIBUTORY (SECONDARY) Senility (duration) yrs. 10 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? (Signed) George Gorman, M.D. (Address) No Bldg

\*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 DATE OF BURIAL Sun Set Burial Park Aug 14 1928

20. UNDERTAKER ADDRESS 2217 Clementine Co S. Grand Blvd

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

