

Registration District No. 5

Primary Registration District No. 1001

Registrar's No. 486

1. PLACE OF DEATH:

(a) County Buchanan
 (b) City or town St. Joseph
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
1358 Buchanan Avenue
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution Not
 In this community 62 years
 years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
 (c) City or town St. Joseph
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1358 Buchanan Avenue
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Maximillian Joseph Andriano

3. (b) If veteran Indian War, 1875 name war
 3. (c) Social Security No. None

4. Sex male
 5. Color or race white
 6. (a) Single, widowed, married, divorced, widowed
 6. (b) Name of husband or wife Elizabeth Andriano
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased January 23 1855
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
87 4 16 hr. min.

9. Birthplace Mannheim Germany
 (City, town, or county) (State or foreign country)

10. Usual occupation Vice President

11. Industry or business First National Bank

MOTHER FATHER { 12. Name Henry Andriano
 13. Birthplace Mannheim Germany
 (City, town, or county) (State or foreign country)
 14. Maiden name Christina Neitz
 15. Birthplace Mannheim Germany
 (City, town, or county) (State or foreign country)

16. (a) Informant Miss Emma Andriano
 (b) Address 1358 Buchanan Ave., St. Joseph, Mo.

17. (a) Burial (b) Date thereof 5-12-1942
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Mora Cemetery
 18. (a) Signature of funeral director Halter Meierhoffer
 (b) Address 13th. & Farson St., St. Joseph, Mo.

19. (a) 5-12-42 (b) Rose Herzog
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 9th.
 year 1942 hour 5 minute 45 P. M.

21. I hereby certify that I attended the deceased from on May 9th
9th to only May 9th
 that I last saw him alive on May 9th and that death occurred on the date and hour stated above.

Immediate cause of death a heart attack and died in it.
 Duration _____

Due to _____

Due to _____

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature S. D. Senior (Physician or other)
 Address 722 Francis Street Date signed 5-11-42

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1233

END

Doc. Johnson

JUL 28 1948

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 _____, Registered Apprentice No. _____, working under my personal supervision.

Signed *Geo E Daniel*

Licensed Embalmer No. 3300 Missouri

P. O. Address St. Joseph, Missouri.

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 this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 17 395

Registration District No. 85

Primary Registration District No. 1001

Registrar's No. _____

1. PLACE OF DEATH: Buchanan
 (a) County: Buchanan
 (b) City or town: St Joseph
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: _____
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution: _____ (Specify whether _____)
 In this community: _____ (years, months or days)

3. (a) PRINT FULL NAME: Maxmillian J. Andriano
 3. (b) If veteran, name war: _____ 3. (c) Social Security No.: _____

4. Sex: M 5. Color or race: W 6. (a) Single, widowed, married, divorced: W
 6. (b) Name of husband or wife: _____ 6. (c) Age of husband or wife if alive: _____ years
 7. Birth date of deceased: Jan 23 1951
 (Month) (Day) (Year)

8. AGE: Years 57 Months 4 Days _____ If less than one day _____ min.

9. Birthplace: _____ (City, town, or county) (State or foreign country)

10. Usual occupation: _____

11. Industry of business: _____

MOTHER FATHER { 12. Name: _____
 13. Birthplace: _____ (City, town, or county) (State or foreign country)
 14. Maiden name: _____
 15. Birthplace: _____ (City, town, or county) (State or foreign country)

16. (a) Informant: _____
 (b) Address: _____

17. (a) _____ (Burial, cremation, or removal) (b) Date thereof: _____ (Month) (Day) (Year)
 (c) Place: burial or cremation: _____

18. (a) Signature of funeral director: _____
 (b) Address: _____

19. (a) _____ (Date received local registrar) (b) _____ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State: _____ (b) County: _____
 (c) City or town: _____ (If outside city or town limits, write "RURAL")
 (d) Street No.: _____ (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country: _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May Day _____ Year 1952 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____, 19____, that I last saw him _____, alive on _____, 19____, and that death occurred on the date and hour stated above.
 (Immediate cause of death: _____)

Due to: Heart attack instant
Coronary thrombosis
 Due to: _____
 Other conditions: _____ (Include pregnancy within 3 months of death) 94a

Major findings: _____
 Of operations: _____
 Of autopsy: _____
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify): _____
 (b) Date of occurrence: _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
Sitting in chair
 While at work? _____ (Specify type of place) (e) Means of injury: _____

23. Signature: Dr. Earl Senior (M. D. or other) _____
 Address: 722 1/2 Francis St Date signed: _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

May 11-52

S-17393

JUL 28 1942