

FILED OCT 22 1944

Registration District No. _____

Primary Registration District No. 1000

Registrar's No. 1037

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:
St. Joseph's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 14 days
(Specify whether years, months or days) 0

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. 2419 So. 17th St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Frank Awender

3. (b) If veteran, name war _____ 3. (c) Social Security No 707-05-8011

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Barbara Awender 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased September 27 1879
(Month) (Day) (Year)

8. AGE: Years 65 Months 0 Days 17 If less than one day hr. _____ min. _____

9. Birthplace 4 Austria
(City, town, or county) (State or foreign country)

10. Usual occupation Hosler for C.B.&O. R.R.

11. Industry or business _____

MOTHER FATHER } 12. Name Jacob Awender

13. Birthplace Austria Hungary 4
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace 9 Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Barbara Awender

(b) Address 2419 So. 17th St.

17. (a) Burial (b) Date thereof Oct. 17, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olivet Cemetery

18. (a) Signature of funeral director Herman W. Sidenfaden

(b) Address 1802 E. St. Joseph, Mo.

19. (a) 10-17-44 (b) Helen J. Gable
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October Day 14th
year 1944 hour 8 minute 20 A.M.

21. I hereby certify that I attended the deceased from Oct 1-4
Oct 14 1944 to Oct 14 1944
that I last saw him alive on Oct 14 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Obstruction of Bowels
Paralytic Ileus Duration 2-6 ds

Due to _____

Due to _____

Other conditions St. Inguinal Hernia
(Include pregnancy within 3 months of death)

Major findings: Of operations Stated above

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) (a) Means of injury _____

23. Signature: Gustav H. _____ (M. D. or other) _____

Address: _____ Date signed: 10/17/44

1377

(Licensed Embalmer's Statement on Reverse Side)

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

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

Robert H Reed

Licensed Embalmer No.

3745

P. O. Address

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