. S. No. 2
M—8-13
v. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 4 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30132

State File No.

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 987

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: 1317 So. 25th St. /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 70 Years
years, months or days)

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. 1317 So. 25th. St. 7
(If rural, give location)
(e) Citizen of foreign country? No. 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Anthony John Foitik
3. (b) If veteran, name war None
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 Rose
6. (c) Age of husband or wife if alive years
7. Birth date of deceased May (Month) 17 (Day) 1866 (Year)

8. AGE: Years 79 Months 3 Days 26 If less than one day hr. min.

9. Birthplace Frankstad (City, town, or county) Austria // (State or foreign country)
10. Usual occupation Retired Tinner
11. Industry or business Armour & Co.
FATHER
12. Name Antone John Foitik
13. Birthplace Frankstad (City, town, or county) Austria 4 (State or foreign country)
MOTHER
14. Maiden name Rosalia Koniakar
15. Birthplace Frankstad (City, town, or county) Austria // (State or foreign country)
16. (a) Informant Mrs. Helen Hruby
(b) Address 1317 So. 25th. St.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sep't.17,45 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Olivet Cemetery
18. (c) Signature of funeral director Herman W. Schuefadie
(b) Address 1802 Union St. St. Joseph, Mo.
19. (a) Sep't.17,45 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 13 year 1945 hour 5 minute 50 P.M.
21. I hereby certify that I attended the deceased from Aug 12 1945 to Sept 13 1945 that I last saw alive on Sept 13 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Addisons Disease with dark bronzing of skin & pigment extending into left flank
Due to Cancer of liver (Huge tense distended abdomen with large nodular palpable liver below margin of ribs)
Due to
Other conditions (Include pregnancy within 3 months of death) I been patient 5 times in all and had no opportunity for laboratory
Major findings: Of operations Laparotomy or autopsy
Of autopsy none made

Duration 4 mo. ?
(?)

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 Gordon Dewright MD (M. D. or other) MD
Address 845 S. 19th St. Jos. Mo. Date signed 9/14/45

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(Licensed Embalmer's Statement on Reverse Side)

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~~ Elmer Thomas, Registered Apprentice No. ....., working under my personal supervision.

Signed Elmer Thomas

Licensed Embalmer No. 2640

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.