

No. 2  
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-17-39  
X35897

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED MAR 27 1946 STANDARD CERTIFICATE OF DEATH**

State File No. **8609**

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 317

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:  
719 Robidoux 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 25 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. 719 Robidoux St  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Peter J. Schaff  
3. (b) If veteran, name war No  
3. (c) Social Security No. 500-07-4565

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month March day 15 year 1946 hour 10 minute A M.

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Elsie  
6. (c) Age of husband or wife if alive 59 years  
7. Birth date of deceased August 6 1889  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov 1, 1945, to March 15, 1946  
that I last saw him alive on March 14, 1946  
and that death occurred on the date and hour stated above.

8. AGE: Years 56 Months 7 Days 9 If less than one day  
hr. \_\_\_\_\_ min \_\_\_\_\_

Immediate cause of death Wraegmle Carcinoma of Prostate Carcinoma of Rectum  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

9. Birthplace Clyde Missouri  
(City, town, or county) (State or foreign country)  
10. Usual occupation Decorator

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED  
Other conditions (Include pregnancy within 3 months of date of death)  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

11. Industry or business \_\_\_\_\_  
12. Name Unknown  
13. Birthplace Unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Elsie Schaff  
(b) Address St Joseph, Mo.  
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-19-46  
(Month) (Day) (Year)  
(c) Place: burial or cremation Mt Olivet Cemetery  
18. (a) Signature of funeral director Fleeman & Son Inc.  
(b) Address St Joseph, Mo.  
19. (a) Mar 19, 1946 (Data received local registrar) (b) [Signature] (Registrar's signature)

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 [Signature] (M. D. or other) \_\_\_\_\_  
Address 825 Fred Ave Date signed 3/16/46

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

MOTHER FATHER

34

APR 1 1946

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, ~~OKBX~~

~~Registered Embalmer No.~~

working under my personal supervision.

Signed *Robert H. Gaylor*

Licensed Embalmer No. 3308

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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. April  
Registrar's No. 317

Registration District No. 42 Primary Registration District No. 1000

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:  
  
(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

Peter J. Schaff

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 m

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years 56 Months 7 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country) MO

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

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 March 15  
year 1986 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;

and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Carcinoma of Prostate

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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) (c) Means of injury \_\_\_\_\_

23. Signature JJ Baumbach (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

**SUPPLEMENTARY**

**ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

754

8609