

**FILED** MAY 2 1946

Registration District No. \_\_\_\_\_

Primary Registration District No. **4001**

Registrar's No. **53**

1. PLACE OF DEATH:

(a) County **Andrew**  
(b) City or town **Savannah**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **Nichols Sanitarium**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **1 month**  
In this community **1 month**  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Florida** (b) County **Brevard**  
(c) City or town **Melbourne**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **Not known**  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Max Otto Schramke**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **Unknown**

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

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

7. Birth date of deceased **August 20 1879**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**65 8 7** hr. min.

9. Birthplace **Milwaukee Wisconsin**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Unknown**

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

MOTHER FATHER { 12. Name **August Schramke**  
13. Birthplace **Unknown Germany**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Unknown**  
15. Birthplace **Unknown Germany**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Claude G. Edge**  
(b) Address **Melbourne, Florida**

17. (a) **Removal** (b) Date thereof **4/27/1946**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Cocoa Ridge, Florida**

18. (a) Signature of funeral director **Arthur Meierhoffer**  
(b) Address **1302 Faraon St. Joseph, Missouri**

19. (a) **4-29-46** (b) **Lillian Spark**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **27<sup>th</sup>** year **1946** hour **2** minute **A** M.

21. I hereby certify that I attended the deceased from **April 15** 19**46** to **April 27** 19**46**  
that I last saw ~~her~~ alive on **April 26** 19**46**  
and that death occurred on the day and hour stated above.

Immediate cause of death **Bronchial Pneumonia** Duration **7 days**

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

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

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

Major findings: Of operations **107** 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? \_\_\_\_\_

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

23. Signature **Max Otto Schramke** (M. D. or other) \_\_\_\_\_  
Address **Savannah Fla** Date signed **4/27/46**

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

MAY 9 1948

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**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..... *Albert E. Harrington*.....  
Licensed Embalmer No. *3258 Mo.*  
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.**