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FILED MAR 22 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 7966

BIRTH NO. _____		REG. DIST. NO. <u>116</u>		PRIMARY REG. DIST. NO. <u>3020</u>		Registrar's No. <u>49</u>	
1. PLACE OF DEATH a. COUNTY <u>Franklin.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Franklin</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Washington.</u>		c. LENGTH OF STAY (in this place) <u>3 hrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Washington</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Francis Hospital.</u>				d. STREET ADDRESS (If rural, give location) <u>533 W. 3rd St.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Cornelius</u>		b. (Middle) _____		c. (Last) <u>Andrae</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Mar. 17th, 1949.</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 30th, 1873.</u>		9. AGE (In years last birthday) <u>75</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>17</u>	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Odd jobs.</u>		11. BIRTHPLACE (State or foreign country) <u>Chesterfield, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Fred Andrae.</u>		13b. MOTHER'S MAIDEN NAME <u>Friedericka Hoffmeister.</u>		14. NAME OF <del>HUSBAND'S</del> WIFE <u>Adeline Andrae.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>None.</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Adeline Andrae</u> <u>Washington, Mo</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hodgkins Disease</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Myocarditis, Chr.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>9 years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>no operation</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>30</u> , to <u>March 17, 1949</u> , that I last saw the deceased alive on <u>March 17, 1949</u> , and that death occurred at <u>12:30 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Frank G. Mays</u> (Degree or title) <u>M.D.</u>				23b. ADDRESS <u>Washington Mo</u>		23c. DATE SIGNED <u>3-18-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Mar. 20, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's Evang. Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Washington, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>Mar. 15, 1949</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u> <u>990</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Hilburg &amp; Vitt, Inc.</u> <u>Washington, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

JAN 13 1950

RECEIVED  
District Health Officer No. 9,  
District Health Officer  
MAR 21 1949

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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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_  
Student Embalmer

Signed Jerome F. Svoboda  
Licensed Embalmer No. 4507

P. O. Address Washington

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.