

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40279**
Registrar's No. **1102**

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000**

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| 1. PLACE OF DEATH a. COUNTY Buchanan | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Buchanan | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph, Mo. | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph, Mo. | |
| c. LENGTH OF STAY (In this place) 1 Year | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION 2725 South 19th Str. | | d. STREET ADDRESS (If rural, give location) 2725 South 19th Street | |

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|-------------------------------------|-------------------------|---------------------------|-----------------------------|---|
| 3. NAME OF DECEASED (Type or Print) | a. (First) Frank | b. (Middle) Joseph | c. (Last) Schoenborn | 4. DATE OF DEATH (Month) (Day) (Year) Dec. 16 1949 |
|-------------------------------------|-------------------------|---------------------------|-----------------------------|---|

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|--------------------|-------------------------------|---|--------------------------------------|---|------------------------|----------------------|-----------------------|----------------------|
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH Jan. 4, 1889 | 9. AGE (In years last birthday) 60 | IF UNDER 1 YEAR Months | IF UNDER 1 YEAR Days | IF UNDER 1 HRS. Hours | IF UNDER 1 HRS. Min. |
|--------------------|-------------------------------|---|--------------------------------------|---|------------------------|----------------------|-----------------------|----------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packing House Wk. | 10b. KIND OF BUSINESS OR INDUSTRY Armour & Co. | 11. BIRTHPLACE (State or foreign country) St. Joseph, Missouri | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
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| 13a. FATHER'S NAME Adam Schoenborn | 13b. MOTHER'S MAIDEN NAME Barbara Herrniger | 14. NAME OF HUSBAND OR WIFE Opal A. |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes Morl War # 1 | 16. SOCIAL SECURITY NO. 491-10-0288 | 17. INFORMANT'S SIGNATURE OR NAME Mrs. Opal A. Schoenborn | ADDRESS 2725 So. 19th |
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| 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, asphyxia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH 4 2/3 hrs. |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary thrombosis Arteriosclerosis heart failure | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis heart disease DUE TO (c) _____ | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
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| 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) |
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| 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? |
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22. I hereby certify that I attended the deceased from **2-5 1948**, to **about 16-17 1949**, that I last saw the deceased alive on **about 19-27 1949**, and that death occurred at **11:30 a.m.**; from the causes and on the date stated above.

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| 23a. SIGNATURE (Degree or title) Ronald J. Stelcher, M.D. | 23b. ADDRESS 902 Edmund, St. Joseph, Mo. | 23c. DATE SIGNED 12-17-49 |
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| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE Dec. 20-49 | 24c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | 24d. LOCATION (City, town, or county) (State) St. Joseph, Missouri |
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| DATE REC'D BY LOCAL REG. Dec. 23, 1949 | REGISTRAR'S SIGNATURE E. C. Jenkins | 382 | 25. FUNERAL DIRECTOR'S SIGNATURE Norman W. Schradew | ADDRESS St. Joseph, Mo. |
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEB 25 1950

DEC 8 1949

VS FEB 10 1950

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.

Student
Student Embalmer

Signed.....

Robert L. Gaylor

Licensed Embalmer No. 3308

P. O. Address *St. Joseph Mrs*

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.