

FILED APR 28 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14257

State File No.

BIRTH NO. _____ REG. DIST. NO. 310 PRIMARY REG. DIST. NO. 3058 Registrar's No. 64

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before a. STATE <u>Mo</u> b. COUNTY <u>St. Charles</u>					
b. CITY (If outside corporate limits, write RURAL and give township) <u>Rural - Callaway</u>		c. LENGTH OF STAY (In this place) <u>Life</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Callaway</u>		0920			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>Near New Melle, Mo.</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Frank</u>			b. (Middle) <u>Sudbrock</u>			c. (Last)			
4. DATE OF DEATH (Month) (Day) (Year) <u>4-13-50</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>			
8. DATE OF BIRTH <u>Feb. 9, 1862</u>		9. AGE (In years last birthday) <u>68</u>		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>St. Charles</u>		12. CITIZEN OF WHAT COUNTRY? <u>No. U.S.</u>			
13a. FATHER'S NAME <u>Frank Sudbrock</u>		13b. MOTHER'S MAIDEN NAME <u>Lowise Schroedermier</u>		14. NAME OF HUSBAND OR WIFE <u>Emma Sudbrock</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Emma Sudbrock, Defiance, 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>Pneumonia</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>Carcinoma</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>49 3X</u> <u>Unknown</u>	
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION <u>None</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>None</u>					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>None</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>None</u>					
22. I hereby certify that I attended the deceased from <u>April 12, 1950</u> , to <u>April 14, 1950</u> that I last saw the deceased alive on <u>April 14, 1950</u> , and that death occurred at <u>12:15 P.M.</u> ; from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>Dr. R. Randall M.D.</u>				23b. ADDRESS <u>207 N. 5th St. St. Charles, Mo.</u>		23c. DATE SIGNED <u>April 14, 1950</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>4-18-50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Lutheran</u>		24d. LOCATION (City, town, or county) (State) <u>New Melle</u>			
DATE REC'D BY LOCAL REG. <u>4-18-50</u>		REGISTRAR'S SIGNATURE <u>Fannie Hewitt</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Morris Mackay</u>		ADDRESS <u>Wentzville</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
APR 21 1950
District Health Officer
District File Number

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 *Morris Muschany*

Licensed Embalmer No. *2469*

P. O. Address *Wentzville*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.