

0.300
0.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39746

FILED DEC 28 1955

State File No.
1323

BIRTH NO. REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No.

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	c. LENGTH OF STAY (in this place) Life	c. CITY OR TOWN St. Joseph	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph's Hospital		e. STREET ADDRESS (If rural, give location) 921 Green St.	0110

3. NAME OF DECEASED (Type or Print) a. (First) Antone b. (Middle) Frank c. (Last) Schraufek Sr.	4. DATE OF DEATH Dec. 16, 1955 (Month) (Day) (Year)
----------------------------------------------------------------------------------------------------	--------------------------------------------------------

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 12, 1881	9. AGE (In years last birthday) 74 IF UNDER 1 YEAR: Months Days IF UNDER 4 HRS: Hours Min.
-------------	------------------------	----------------------------------------------------------------	--------------------------------	-----------------------------------------------------------------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. (4) Bottling House	10b. KIND OF BUSINESS OR INDUSTRY Goetz Brew.	11. BIRTHPLACE (City and State or Foreign Country) St. Joseph, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------	--------------------------------------------------------------------	-------------------------------------

13a. FATHER'S NAME Antone Schraufek	13b. MOTHER'S MAIDEN NAME Caroline Nix	14. NAME OF HUSBAND OR WIFE Josephine
-------------------------------------	----------------------------------------	---------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 491-09-8794	17. INFORMANT'S SIGNATURE OR NAME Mrs A.F. Schraufek	ADDRESS 921 Green City
---------------------------------------------------------------------	----------------------------------------------------------------------------	------------------------------------------------------	------------------------

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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH instantly several weeks several days several years
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary thrombosis		
	ANTECEDENT CAUSES DUE TO (b) Congestive heart failure Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) Pulmonary congestion and edema II. OTHER SIGNIFICANT CONDITIONS Arteriosclerotic heart disease (decompensated) Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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) m.	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 1945, 19, to 12-16-55, 19, that I last saw the deceased alive on 12-16-55, 19, and that death occurred at 1:25a m., from the causes and on the date stated above.

23a. SIGNATURE E. H. Anderson	(Degree or title) M.D.	23b. ADDRESS 311 Physician & Surgeons Bldg., St. Joseph, Mo.	23c. DATE SIGNED 12-16-55
-------------------------------	------------------------	--------------------------------------------------------------	---------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Dec. 19, 1955	24c. NAME OF CEMETERY OR CREMATORY Mt. Olivet	24d. LOCATION (City, town, or county) (State) St. Joseph, Mo.
--------------------------------------------------	-------------------------	-----------------------------------------------	---------------------------------------------------------------

DATE REC'D BY LOCAL REG. Dec. 19, 1955	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE [Signature]	ADDRESS St. Joseph, Mo.
----------------------------------------	-----------------------------------	----------------------------------------------	-------------------------

(Licensed Embalmer's Statement on Reverse Side)

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

Handled

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.....
Signature of Student Embalmer

Signed..... *Robert H. Gage*

Licensed Embalmer No.. 3308.

P. O. Address St. Joseph,

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.