

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED APR 26 1956

State File No. **14836**  
Registrar's No. **3609**

**318**

**1003**

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		State File No. <b>14836</b>		Registrar's No. <b>3609</b>			
1. PLACE OF DEATH a. COUNTY <b>Missouri</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY							
b. CITY OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place) <b>5 days</b>		c. CITY OR TOWN <b>St. Louis</b>		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 <b>Chronic Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>24 2825 Chippewa St. 2247</b>							
3. NAME OF DECEASED (Type or Print) a. (First) <b>Lawrence</b> b. (Middle) <b>Frank</b> c. (Last) <b>Schaaf</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>4/10/56</b>								
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>separated</b>		8. DATE OF BIRTH <b>6/27/1913</b>		9. AGE (In years last birthday) <b>42</b>		IF UNDER 1 YEAR Months <b>9</b> Days <b>13</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bricklayer</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Missouri</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13a. FATHER'S NAME <b>Oscar Schaaf</b>			13b. MOTHER'S MAIDEN NAME <b>Bertha Ritterbusch</b>			14. NAME OF HUSBAND OR WIFE <b>Florence Schaaf</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Chronic Hospital, 5600 Arsenal</b>						
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 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Cortical Damage</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 1/4 months</b>		
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Cerebral Anoxia</b>							" "		
		DUE TO (c) <b>Cardiac Arrest</b>							" "		
		11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Multiple Decubita Ulcer Terminal Bronchopneumonia</b>									
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>355x</b>							20. AUTOPSY? YES <input type="checkbox"/> NO <input 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 <b>4/5/56</b> , 19 <b>56</b> , to <b>4/10</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>4/10</b> , 19 <b>56</b> and that death occurred at <b>9:35P.m.</b> , from the causes and on the date stated above.											
23a. SIGNATURE <b>George M. Janaka, M.D.</b> (Degree or title)				23b. ADDRESS <b>5600 Arsenal</b>			23c. DATE SIGNED <b>Apr. 11, 1956</b>				
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>4/12/56</b>		24c. NAME OF CEMETERY OR CREMATORY <b>New St. Marcus Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>					
DATE REC'D BY LOCAL REG. <b>APR 11 1956</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>John H. Gebken Sons 2630 Gravois Ave.</b>						

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

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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..

Student.....  
Signature of Student Embalmer

Signed..... *Robert T. Gebken*

Licensed Embalmer No..... 4144

P. O. Address 2630 Gravois

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.