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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-000347
STATE FILE NUMBER

FILED JAN 12 1959 Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 10

1. PLACE OF DEATH
a. COUNTY: Buchanan
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): St. Joseph — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Mo. Meth. Hospital — Length of stay in 1b: 60 years.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Buchanan
c. CITY OR TOWN: St. Joseph — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 1723 Dewey Ave. — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: Frederick Middle: Last: Shamrad

4. DATE OF DEATH Month Day Year: January 4, 1959.

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: May 22, 1882
9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Owner of Shamrad Boiler Factory
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): Austria.
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: Joseph Shamrad
13b. MOTHER'S MAIDEN NAME: Mary Korinek
14. NAME OF HUSBAND OR WIFE: Edith W. Shamrad

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 491-09-1836
17. INFORMANT: Mrs. Edith W. Shamrad Address: St. Joseph, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of prostate — INTERVAL BETWEEN ONSET AND DEATH: 8 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 177X

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 4/1/54, to 1/4/59 and last saw ~~her~~ him alive on 1/4/59
Death occurred at 3:15 P.m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: H. L. Warres (Degree or title): M.D.
22b. ADDRESS: St. Joseph, Mo.
22c. DATE SIGNED: 1/5/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Entombment
23b. DATE: January 7, 1959.
23c. NAME OF CEMETERY OR CREMATORY: Ashland Mausoleum
23d. LOCATION (City, town, or county) (State): St. Joseph, Missouri.

24. FUNERAL DIRECTOR: Meierhoffer-Fleeman, Inc. ADDRESS: St. Joseph, Mo.
25. DATE RECD. BY LOCAL REG.: Jan 7, 1959
26. REGISTRAR'S SIGNATURE: Mrs. Clark Goodell

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

Dr. H. L. Warres

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 ...[illegible]...

Licensed Embalmer No.....

P. O. Address ...St. Joseph, Mo.

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.