

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019591

STATE FILE NUMBER
Registration District No. 2 Primary Registration District No. 2
Register No. 5289

FILED JUN 15 1959

300

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis		c. CITY OR TOWN St. Louis	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 3539 Page	
Length of stay in 1b		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) Mike A. SCHARAFINSKI			4. DATE OF DEATH Month 5 Day 28 Year 59		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 11, 1894	9. AGE (In years last birthday) 64	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Polisher	10b. KIND OF BUSINESS OR INDUSTRY Metal Products Co.	11. BIRTHPLACE (City and state or country) St. Louis, Missouri.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Michael A. Scharafinski	13b. MOTHER'S MAIDEN NAME Anna Dreising	14. NAME OF HUSBAND OR WIFE Celina L. Scharafinski Anne
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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) No.	16. SOCIAL SECURITY NO. 492-03-4213	17. INFORMANT Celina L. Scharafinski Address 6309 Alaska Ave.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia		INTERVAL BETWEEN ONSET AND DEATH undet.
Conditions, if any, which gave rise to above cause (a), starting the underlying cause last.	DUE TO (b) Chronic Pyelonephritis 600.0	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Generalized Arteriosclerosis.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in PART I or PART II of item 18.) ITEM 14, 17 CORRECTED BY AFFIDAVIT OF Funeral Director 6-29-59 JCL
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from 5-25-59 to 5-28-59 and last saw ^{him} alive on 5-28-59 Death occurred at 7:50 P m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE A. G. Inase (Degree or title) 0	22b. ADDRESS 2601 Whittier Street	22c. DATE SIGNED 6-1-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 6-3-59	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
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24. FUNERAL DIRECTOR Albert H. Hoppe Inc. ADDRESS 4700 Washington,	25. DATE RECD. BY LOCAL REG. JUN 2 '59	26. REGISTRAR'S SIGNATURE Dr. Earl Smith, M.D.
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Any diseases in part I must be causally related.

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 *W. Wilkinson*

Licensed Embalmer No. *35-75*

P. O. Address *M. P.*

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.