

7. S. No. 2  
FORM-5-43  
Rev. 5-17-39  
X 36671

11590

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED MAR 24 1947

318

Primary Registration District No. ....

1003

Registrar's No. 2467

1. PLACE OF DEATH:

(a) County St. Louis, Mo.

(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Barnes Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution hospital  
(Specify whether years, months or days) 60 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 4333 Maryland Ave 199  
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country.....

3. (a) PRINT FULL NAME Philip Skrainka

3. (b) If veteran, name war.....

3. (c) Social Security No.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 7  
year 1947 hour 9 minute 55 P.M.

21. I hereby certify that I attended the deceased from 1-7-47  
....., 1947 to 3-7- 1947;

4. Sex MALE 5. Color or race W

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife.....

6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased Feb. 14 1864  
(Month) (Day) (Year)

that I last saw him alive on March 7 1947;  
and that death occurred on the date and hour stated above.

Immediate cause of death Thrombosis coronary artery, right Duration

Due to Carcinoma of sigmoid colon, with metastases to liver.

8. AGE: Years Months Days If less than one day

83 0 23 hr. min.

Due to.....

Other conditions (Include pregnancy within 3 months of death) Hb

9. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Medical Doctor

Major findings: Of operations.....

Of autopsy Same as above plus benign prostatic hypertrophy

22. If death was due to external causes, fill in the following:

11. Industry or business.....

12. Name Phillip Skrainka 4

13. Birthplace Hungary  
(City, town, or county) (State or foreign country)

14. Maiden name Regina Schmiedler

15. Birthplace Hungary  
(City, town, or county) (State or foreign country)

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur?..... (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?.....

While at work? (Specify type of place)..... (e) Means of injury.....

16. (a) Informant Catherine C. Wisk

(b) Address 408 Olive Street

17. (a) Cremation (b) Date thereof 3/10/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla

23. Signature F. R. Brasley (M. D. or other) 0

Address Barnes Hospital Date signed 3-8-47

18. (a) Signature of funeral director Wagoner

(b) Address 4161 Luedell Blvd.

19. (a) MAR 10 1947 (Date received local registrar)

J. J. Brudeck (Registrar's signature)

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

MOTHER FATHER

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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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed *Neville B. Frohwitter*.....

Licensed Embalmer No. *3696*.....

P. O. Address.....

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