

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Registration District No. **751**

Primary Registration District No. **5992**

Registrar's No. **1415**

1. PLACE OF DEATH: **9**

(a) County Ripley

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

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

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 34 years, months or days)

3. (a) PRINT FULL NAME Anthony Nowak

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male

5. Color or race Polish

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

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

6. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased May-15-1865
(Month) (Day) (Year)

8. AGE: Years 74 Months 5 Days 30 If less than one day hr. _____ min. _____

9. Birthplace Polska Poland
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business _____

MOTHER FATHER { 12. Name Jacob Nowak

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

14. Maiden name unknown

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

16. (a) Informant's own signature Leo Nowak

(b) Address Douglas Mo.

17. (a) Rural (b) Date thereof 11-17-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Joseph's Cemetery

18. (a) Signature of funeral director J. E. Jordan

(b) Address Douglas Mo.

19. (a) 11/15 1939 (b) St. Elizabeth
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: **1**

(a) State Mo. (b) County Ripley

(c) City or town Varnier Twp.
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A. 50 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 14
year 1939, hour 11 minute 30 P. M.

21. I hereby certify that I attended the deceased from Oct 1, 1939, to Nov 11, 1939;
that I last saw him alive on Nov 8, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death myocardial infarction

Due to hypertension with mural thrombosis

Due to myocardial infarction

Other conditions None
(Include pregnancy within 3 months of death)

Duration ?

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

Major findings: None

Of operations _____

Of autopsy _____

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

(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 _____

23. Signature St. Elizabeth (M. D. or other) ✓

Address Douglas Mo. Date signed 11/15/39

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.....

RECEIVED

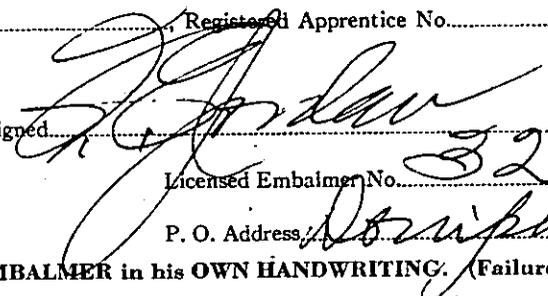
Working under my personal supervision.

District Health Officer No. 5,

District File Number. 140 95-

Date Filed 11 24 0

....., Registered Apprentice No.

Signed 

Licensed Embalmer No. 3200

P. O. Address Derripham

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, above space should be left blank.