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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 19 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 28453

Registration District No. 247 Primary Registration District No. 3016 Registrar's No. 79

1. PLACE OF DEATH:

(a) County Franklin

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

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

(d) Length of stay: In hospital or institution 13 hrs (Specify whether

In this community 1 da. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin

(c) City or town Washington (If outside city or town limits, write "RURAL")

(d) Street No. 629 S Elm St. (If rural, give location)

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

3. (a) PRINT FULL NAME Victor Wensel Kosark

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race White

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 August (Month) 20 (Day) 1940 (Year)

8. AGE: Years | Months | Days 6 | If less than one day hr. min.

9. Birthplace Washington (City, town, or county) Missouri (State or foreign country)

10. Usual occupation None

11. Industry or business "

FATHER
12. Name Victor Wensel Kosark
13. Birthplace Owensville (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Katie Trevil Jett
15. Birthplace Cooper Hill (City, town, or county) Missouri (State or foreign country)

16. (a) Informant's own signature Victor W. Kosark

(b) Address Owensville, MO.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-28-1940 (Month) (Day) (Year)

(c) Place: burial or cremation BLAND, MO ~~Union Cem.~~

18. (a) Signature of funeral director W. F. Gatterstraeter

(b) Address Owensville Mo.

19. (a) Aug. 27-1940 (Date received local registrar) (b) H. A. May (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 26 year 1940 hour 7 30 minute 8 M.

21. I hereby certify that I attended the deceased from Aug 20, 1940 Aug 26, 1940 to ——, 19__; that I last saw him alive on August 26, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Hemorrhagic Disease of the Newborn	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

16 D/B

Major findings:
Of operations
Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically

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? (Specify type of place)

2 10

While at work? (e) Means of injury

23. Signature J. P. Post (M. D. ~~or other~~) 1

Address Washington Mo Date signed 8/27/40

(Licensed Embalmer's Statement on Reverse Side)

J. P. Post.

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 Me

....., Registered Apprentice No.....

working under my personal supervision.

Signed Milford H. H. Hunter

Licensed Embalmer No. 3838

P. O. Address Owensville Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.