

11-10-39
5-17-39
I X21492

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

NOV DEC 10 1940

Registration District No. **213**

Primary Registration District No. **3014**

Registrar's No. **295**

1. PLACE OF DEATH:

(a) County **COLE**

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

(c) Name of hospital or institution: **ST. MARYS HOSP.**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **3 WEEKS**
(Specify whether)

In this community **1**
years, months or days

3. (a) PRINT FULL NAME **JOSEPH 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 **MARRIED**

6. (b) Name of husband or wife **LYDIA KOSARK**

6. (c) Age of husband or wife if alive **70** years

7. Birth date of deceased **JAN 30 1866**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
74	10	11	hr. min.

9. Birthplace **Quensville MISSOURI**
(City, town, or county) (State or foreign country)

10. Usual occupation **FARMER**

11. Industry or business

12. Name **ALBERT KOSARK**

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

14. Maiden name **HELEN REED**

15. Birthplace **Quensville MISSOURI**
(City, town, or county) (State or foreign country)

16. (a) Informant **Joseph Kosark**

(b) Address **Quensville Mo.**

17. (a) **BURIAL** (b) Date thereof **11-15-1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **ROSEBUD METHODIST CH.**

18. (a) Signature of funeral director **W. F. Hattenstadt**

(b) Address **Quensville Mo.**

19. (a) **11-12-40** (b) **Dupe of form D**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **GASCONADE**

(c) City or town **NEAR ROSEBUD MO.**
(If outside city or town limits write "RURAL")

(d) Street No. **0**
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **NOV.** day **11th**
year **1940** hour **11** minute **40 P.M.**

21. I hereby certify that I attended the deceased from **Oct 28**, 19**40** to **Nov 11th**, 19**40**
that I last saw him alive on **Nov 11**, 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Cardio-Vascular Disease with Coronal Failure**

Due to **Acute abdominal Disease**

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: 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? **!!!**

23. Signature **Joseph Kosark M.D.** (Specify type of place) _____
While at work (a) Means of injury _____

Address **Jefferson City Mo.** Date signed **11/12/40**

Duration **1 28**

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

95192

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 M.L.

Registered Apprentice No. _____

working under my personal supervision.

Signed W.F. Gettenroeter

Licensed Embalmer No. 1448

P. O. Address Owensville 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 this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 385-28

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 213

Primary Registration District No. 3014

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Calderwood
(b) City or town Jefferson
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Joseph Kasark

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced in

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 74 Months 10 Days 11 If less than one day _____ hr _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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. ? _____ years.

19. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 11
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiovascular disease, cardiac failure. Duration _____

Due to acute abdominal dis-
ease, undetermined.

Other conditions _____ (include pregnancy within 3 months of death) 95 H²

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? _____

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

23. Signature John W. McHenry (M. D. or other) MD
Address Jefferson City Date signed 11/11/40

SUPPLEMENTARY

