

MAR 19 1941

Registration District No. 51

Primary Registration District No. 2990

Registrar's No. 1459

1. PLACE OF DEATH: Ripley
(a) County
(b) City or town rural Thomas township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State mo (b) County Ripley 91
(c) City or town rural (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

3. (a) PRINT FULL NAME Anton Kovacic
(b) If veteran, name war _____ (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec day 29 year 1941 hour 5 minute AM

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced ✓
6. (b) Name of husband or wife Mary Kovacic 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Jan 28 1878 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov 3 1939, to Jan 1 1939; that I last saw him alive on Jan 10 1939; and that death occurred on the date and hour stated above.

8. AGE: Years 66 Months 11 Days 1 If less than one day _____ hr. _____ min.

Immediate cause of death spastic form progressive muscular atrophy
Due to _____
Due to _____

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

Other conditions Chronic prostatic (include pregnancy within 3 months of death)
Major findings: Of operations _____ Of autopsy _____

10. Usual occupation Farmer

MOTHER FATHER
11. Industry or business _____
12. Name unknown
13. Birthplace unknown (City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace unknown (City, town, or county) (State or foreign country)

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 _____

16. (a) Informant Steve Kovacic
(b) Address Naylor mo 21

17. (a) _____ (b) Date thereof 1-1-40 (Month) (Day) (Year)
(c) Place: burial or cremation Funerary

18. (a) Signature of funeral director Minnie Gosh
(b) Address Naylor mo

19. (a) 12/29/40 (b) H. E. White (Date issued local registrar) (Registrar's signature)

23. Signature H. E. White (M. D. or other) ✓
Address Naylor mo Date signed 12/29/40

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

71
0
0

09-15-5-11
CLASSIC

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.....

Licensed Embalmer No.....

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.

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

 DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
State File No. 4053
79-75-

Registration District No. 751

Primary Registration District No. 5990

Registrar's No.

1. PLACE OF DEATH:

 (a) County Rosley
 (b) City or town Thompson Twp
 (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 _____ (Specify whether

 In this community _____
 years, months or days
3. (a) PRINT FULL NAME Anton Kovacic

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 _____

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

 7. Birth date of deceased Jan 28 1878
 (Month) (Day) (Year)

 8. AGE: Years 62 Months 11 Days 1 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 _____
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

 19. (a) 12/29-40 (b) H. E. White
 (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.

MEDICAL CERTIFICATION

 20. DATE OF DEATH Month Dec day 29
 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 _____

Due to _____

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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

 Underline
 the cause to
 which death
 should be
 charged sta-
 tistically.

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

SUPPLEMENTAL COPY

