

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED FEB 13 1943

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. 116

Primary Registration District No. 5434

Registrar's No. 4

1. PLACE OF DEATH:

(a) County Franklin

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

(c) Name of hospital or institution:  
St. Ann's Home R. F. D. # 2  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution None  
(Specify whether)

In this community 78 yrs.  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin

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

(d) Street No. R. F. D. # 2  
(If rural, give location)

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

If yes, name country ✓

3. (a) PRINT FULL NAME Julia Mikos

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month January day 13  
year 1943 hour 9:00 minute P. M.

4. Sex Female 5. Color or trace 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 May 22 1864  
(Month) (Day) (Year)

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 Coronary Thrombosis

8. AGE:	Years	Months	Days	If less than one day
	<u>78</u>	<u>7</u>	<u>21</u>	hr. _____ min. _____

Due to \_\_\_\_\_

Due to was found dead in bed by neighbors, been dead for several days

9. Birthplace Washington (R.#2) Missouri  
(City, town or county) (State or foreign country)

Other conditions for several days  
(Include pregnancy within 3 months of death)

10. Usual occupation Housework

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

11. Industry or business ✓

Major findings: 940

Of operation \_\_\_\_\_

Of autopsy \_\_\_\_\_

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Mrs. Joseph Kluba

(b) Address Washington, Mo. R. # 2

17. (a) Burial (b) Date thereof Jan 16 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington, Mo. R# 2

18. (a) Signature of funeral director Theberg & Co., Inc.

(b) Address Washington, Mo.

19. (a) Jan 16 43 (b) L. C. Ruetter  
(Date received local registrar) (Registrar's signature)

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)

(c) Means of injury Coroner

23. Signature Gerald M. ... (or other) \_\_\_\_\_

Address Gerald Mo Date signed 1-15-43

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

36  
00  
6

**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

Lester A. Pitt

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

Lester A. Pitt

Licensed Embalmer No. 3254

P. O. Address Washington, 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, fact should be so stated above.**