

FILED SEP 18 1944

Registration District No. 299

Primary Registration District No. 6027

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Reynolds
 (b) City or town Carrollton R.R. #1
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Jackson Hosp
(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 Anna Biconas

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife Anton Biconas 6. (c) Age of husband or wife if alive 85 years

7. Birth date of deceased: October 23, 1870
(Month) (Day) (Year)

8. AGE: Years 74 Months 10 Days 13
If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER

12. Name Unknown 9

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

14. Maiden name Unknown 9

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

16. (a) Informant J. A. Biconas

(b) Address Carrollton, Mo.

17. (a) burial (b) Date thereof Sept 15, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pilot Knob, Mo.

18. (a) Signature of funeral director M. R. White & Sons

(b) Address Ironton, Mo.

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Reynolds
 (c) City or town R.R. #1
(If outside city or town limits, write "RURAL")
 (d) Street No. 2 miles east of Carrollton Mo.
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 18
 year 1944 hour 5 minute 30 A.M.

21. I hereby certify that I attended the deceased from July 15
 1944 to Sept 13 1944

that I last saw her alive on August 6 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death C. bronch
Bright's disease Duration 3 years

Due to _____

Due to _____

Other conditions Arteriosclerosis 3 years
(Include pregnancy within 3 months of death)

Major findings: hypertension 131 f

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 A. J. Buss, M.D. (M. D. or other) _____

Address Ellington, Mo. Date signed 9-13-44

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

RECEIVED

District Health Officer No. 5,
District File Number 944486
Date Filed 9-15-44

OCT 6 1944

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 Lyle A. White

Licensed Embalmer No. 4295

P. O. Address Proctor, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. oct

Registration District No. 299

Primary Registration District No. 6027

Registrar's No. _____

1. PLACE OF DEATH

(a) County Reynolds
(b) City or town Paul Jackson sup
(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 Anna Bickman

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

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

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

7. Birth date of deceased Oct 23
(Month) (Day) (Year)

8. AGE: Years 74 Months 10 Days 3 If less than one day _____ min.

9. Birthplace Kansas
(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) Sept 13/44 (b) Mrs. Mary Wellington
(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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept year 1944 minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____

that I last saw him _____ alive on _____ 19 _____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration _____

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 _____

Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

**ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED**

PHYSICIAN

Underline the cause to which death should be charged statistically.

31596