

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **34195**

FILED NOV 13 1944

Registration District No. **1/8**

Primary Registration District No. **4188**

Registrar's No. **102**

1. PLACE OF DEATH:

(a) County **Gasconade**
(b) City or town **Owensville**
(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) **1**
(d) Length of stay: In hospital or institution. (Specify whether)
In this community **20 years** years, months or days

3. (a) PRINT FULL NAME **GENEVIEVE ROSE DUDA**

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 **Single**
6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive **2** years
7. Birth date of deceased **January 2 1912** (Month) (Day) (Year)

8. AGE: Years **32** Months **9** Days **8** If less than one day **-** hr. **-** min.

9. Birthplace **Muskegon Michigan** (City, town, or county) (State or foreign country)

10. Usual occupation **Office worker**

11. Industry or business

12. Name **John Duda**

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

14. Maiden name **Bielenska**

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

16. (a) Informant **John Duda**

(b) Address **Owensville Mo.**

17. (a) **Burial** (b) Date thereof **10-14-44** (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Owensville Catholic**

18. (a) Signature of funeral director **Wilford W. Winter**

(b) Address **Owensville, Mo.**

19. (a) **Oct. 13, 1944** (b) **Myrtle M. Wenkel** (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Gasconade**
(c) City or town **Owensville** (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **D**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **10** year **1944** hour **-** minute **-** M.

21. I hereby certify that I attended the deceased from **Oct. 4** 19**44** to **Oct. 10** 19**44**
that I last saw her alive on **Oct. 9** 19**44**
and that death occurred on the date and hour stated above.

Immediate cause of death **Bronchopneumonia** Duration **7 d/s**

Due to **36**

Other conditions **Paralysis of upper and lower extremities following poliomyelitis**

Major findings: **None** Of operations **None**

Of autopsy **None**

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 **D**

23. Signature **Paul A. Brunner** (M. D. or other) **MD**

Address **Owensville, Mo.** Date signed **10-11-44**

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

NOV 28 1944

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed..... 11-8-44

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.....

Melford Winters

Licensed Embalmer No. 383F

P. O. Address..... *Quincyville, Md.*

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.