

FILED APR 9 1945  
290

State File No. ....

Registration District No. .... 290

Primary Registration District No. .... 5983

Registrar's No. .... 24

1. PLACE OF DEATH:

(a) County Pulaski

(b) City or town Waynesville (Rural) Cullen T.  
(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 10 Years (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pulaski

(c) City or town Rural (Cullen T. S.)  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME Karl Herman Marks

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 Myrtle Marks 6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased Sept. 12, 1868  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

76	6	4	hr. min.
----	---	---	----------

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

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name Not Known

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

14. Maiden name Not Known

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

16. (a) Informant Myrtle Marks

(b) Address Waynesville, Mo.

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

(c) Place: burial or cremation Crocker, Mo.

18. (a) Signature of funeral director J. L. Hoops & Sons

(b) Address Crocker, Mo.

19. (a) 9-22-1945 (b) Health Wadd  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mch. day 16,  
year 1945 hour 7 minute A. M.

21. I hereby certify that I attended the deceased from 3-1  
1945 to 3-20 1945  
that I last saw him alive on 3-20 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia  
Duration 8 days

Due to operative removal of prostate gland.

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 E. Miller M.D. (M. D. or other)

Address Waynesville, Mo. Date signed 3-20-45

Duration

8 days

ADDITIONAL  
SUPPLEMENTARY  
INFORMATION  
REQUESTED

PHYSICIAN

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

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

**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.....

*Paul B Hoop*

Licensed Embalmer No.....

*3261*

P. O. Address.....

*Waynesville, N.C.*

**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.**

Registration District No. 290

Primary Registration District No. 5983

1. PLACE OF DEATH:

(a) County Pulaski  
(b) City or town Rural Cullen 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

Karl H. Marks

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 M

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Sept. 12

(Month) (Day) (Year)

8. AGE:

Years 76

Months 6

Days \_\_\_\_\_

If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_

(City, town, or county)

(State or foreign country) Germany

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) \_\_\_\_\_ (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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Chronic nephritis  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (include pregnancy within 3 months of death)

Duration

Major findings: Of operations \_\_\_\_\_

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

ADDITIONAL

121 SUPPLEMENTARY INFORMATION REQUESTED

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 C. Miller, M.D. (M. D. or other) \_\_\_\_\_  
Address Waynesville, Mo. Date signed 4-15-45

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

SUPPLEMENTARY

10475