

**FILED** JUN 14 1945

Registration District No. \_\_\_\_\_

Primary Registration District No. 3008

Registrar's No. 184

1. PLACE OF DEATH:

(a) County Calloway  
(b) City or town Fulton  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution State Hospital No 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 month 23 days  
(Specify whether \_\_\_\_\_)  
In this community same  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lincoln  
(c) City or town Tracy  
(If outside city or town limits, write "RURAL")  
(d) Street No. RFD 3 (If rural, give location)  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ROSA MASHK

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 Joe Mashk  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Aug 30 1900  
(Month) (Day) (Year)

8. AGE: Years 44 Months 9 Days 2  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Tracy Mo  
(City, town, or country) (State or foreign country)

10. Usual occupation housewife

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

12. Name Frank Jiske

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

14. Maiden name Anna Mallon

15. Birthplace Tracy Mo  
(City, town, or country) (State or foreign country)

16. (a) Informant Records State Hosp No 1

(b) Address Fulton Mo

17. (a) Removal (b) Date thereof 6/5/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Troy, Mo

18. (a) Signature of funeral director Wallace Funeral Home

(b) Address Fulton, Mo (D.C. Browning mgr)

19. (a) 6-5-1945 (b) Joie Mouskopf  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 2  
year 1945 hour 5 minute 9 M.

21. I hereby certify that I attended the deceased from Jun 2 1945 to Jul 2 1945  
that I last saw her alive on Jun 2 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

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

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

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations g/20

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

Duration

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? \_\_\_\_\_

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

23. Signature [Signature] (M. D. or other) MD

Address Fulton Mo Date signed 6/2/45

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

14  
1  
2

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 7-13-45

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**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 Denzil P. Browning  
Licensed Embalmer No. 2724  
P. O. Address Tulsa 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.**