

No. 2  
-5-43  
-17-39  
X36671

**FILED** SEP 21 1945  
Registration District No. **383**

Primary Registration District No. **0605**

Registrar's No. **109**

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

1. PLACE OF DEATH:

(a) County Laurens

(b) City or town Mount Vernon, Mo.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Missouri State Sanatorium  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 377 days  
(Specify whether years, months or days)

In this community 377 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Wasson

(c) City or town Owensville  
(If outside city or town limits, write "RURAL")

(d) Street No. Route #3  
(If rural, give location)

(e) Citizen of foreign country? 1 (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Evelyn Margaret Nowack

3. (b) If veteran, name war no

3. (c) Social Security No. 487-22-0627

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 \_\_\_\_\_ years

7. Birth date of deceased September 7 1923  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>21</u>	<u>11</u>	<u>21</u>	_____ hr. _____ min.

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

10. Usual occupation Shoe Factory

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

12. Name W. F. Nowack

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

14. Maiden name Wilhelmina School

15. Birthplace Red Bud Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant E. Michalski, Record Clerk

(b) Address Mo. State San, Mount Vernon, Mo.

17. (a) Funeral (Burial, cremation, or removal) (b) Date thereof Aug 28-1945  
(Month) (Day) (Year)

(c) Place: burial or cremation Owensville Mo

18. (a) Signature of funeral director W. F. Gottenstroeter

(b) Address Owensville Mo

19. (a) 8/20/45 (Date received local registrar) (b) Audrey Crawford (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 28 year 1945 hour 12 minute 55.9 M.

21. I hereby certify that I attended the deceased from August 17, 1944 to August 28, 1945 that I last saw her alive on August 28, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis over 2 yrs

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

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

Other conditions 1  
(Include pregnancy within 3 months of death)

Major findings: 13/4

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 0

23. Signature Charles A. Braden, M.D. (M. D. or other)

Address Mo. State San. Date signed 8-28-45

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

RECEIVED  
District Health Officer No. 6;  
District File Number 945-950  
Date Filed SEP 19 1945

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.....

*George B. Orr*

Licensed Embalmer No.....

*946*

P. O. Address.....

*Mt Vernon 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.**