

FILED NOV 6 1945

Registration District No. 110

Primary Registration District No. 3020

Registrar's No. 101

1. PLACE OF DEATH:

(a) County Franklin
(b) City or town Washington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Francis 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 40 yrs
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Franklin St.
(c) City or town Washington Mo 6
(If outside city or town limits, write "RURAL")
(d) Street No. 702 Walnut St
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME ANNA KLUBA

3. (b) If veteran, name war none
3. (c) Social Security No. none

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (c) Age of husband or wife if alive 51 years
7. Birth date of deceased April 8-13-1876
(Month) (Day) (Year)

8. AGE: Years 69 Months 6 Days 6
If less than one day _____ hr. _____ min.

9. Birthplace Clow Ballou Mo. C.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____
12. Name Peter Mouzyk
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Susan Mouzyk
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Herman Lybanc
(b) Address Washington Mo

17. (a) Burial (b) Date thereof 10-22-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Washington Mo

18. (a) Signature of funeral director Oct 26
(b) Address Washington Mo
19. (a) 10/23/45 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 19
year 1945 hour 6 minute 10 M.

21. I hereby certify that I attended the deceased from Oct 21
1945, to Oct 19, 1945
that I last saw her alive on Oct 19, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Pernicious
Anemia Duration _____

Due to _____
Due to _____

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

Major findings:
Of operations _____
Of autopsy _____
730

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) M.D.
Address 907 Jefferson Washington Mo Date signed 10/20/45

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

36
5

1449

RECEIVED
District Health Officer No. 9,

District File Number _____

Date Filed 11-5-45

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 *J. H. Otto*

Licensed Embalmer No. 2464

P. O. Address Washington 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.