

S. No. 2
FORM-2-43
Rev. 5-17-39
1 X35697

DEPARTMENT OF COMMERCE
BUREAU OF HEALTH
STATE BOARD OF HEALTH OF MISSOURI
FILED OCT 17 1946
STANDARD CERTIFICATE OF DEATH

State File No. **33238**
Registration District No. **118**
Primary Registration District No. **4188**
Registrar's No. **23**

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: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community 39 years
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Gasconade **37**
(c) City or town Owensville **2**
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME FRANCES JONAS
3. (b) If veteran, name war ✓
3. (c) Social Security No. 499-24-3010
4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Stanley Jonas
6. (c) Age of husband or wife if alive 17 years
7. Birth date of deceased January 17 1887
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month September day 21
year 1946 hour 1 minute 40 P.M.
21. I hereby certify that I attended the deceased from 9-19 1946, to 9-21 1946
that I last saw her alive on 9-21 1946
and that death occurred on the date and hour stated above.
Immediate cause of death Right Hemiplegia Duration
Due to Cerebral Hemorrhage
On Hypertensive Basis 36 hrs.

8. AGE: Years Months Days If less than one day
59 8 4 - hr. - min.

Due to.....
Due to.....

9. Birthplace Bohemia
(City, town, or county) (State or foreign country)
10. Usual occupation Housework & factory

Other conditions None
(Includes pregnancy within 3 months of death)

11. Industry or business
12. Name Jacob Dolejsi
13. Birthplace Bohemia
(City, town, or county) (State or foreign country)
14. Maiden name Anna
15. Birthplace Bohemia
(City, town, or county) (State or foreign country)

Major findings:
Of operations —
Of autopsy —
PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant Stanley Jonas
(b) Address Owensville, Mo.
17. (a) Burial (b) Date thereof 9 24 1946
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Catholic Cemetery - Owensville
18. (a) Signature of funeral director Myrtle N. Winter
(b) Address Owensville, Mo.
19. (a) 10-11-46 (b) Dorothy Hackman
(Date received local registrar) (Registrar's signature)

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 Paul D. Brant (M.D. or other)
Address Owensville, Mo. Date signed 9-23-46

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

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(Licensed Embalmer's Statement on Reverse Side)

Date Filed 10-15-46

District File Number _____

District Health Officer No. 9

RECEIVED

OCT 24 1946

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 Wesford N. H. Winter

Licensed Embalmer No. 3838

P. O. Address Owensville 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.