

No. 2  
8-43  
7-39  
X37823

FILED MAR 4 1947

Registration District No. 290

Primary Registration District No. 4427

Registrar's No. 10

1. PLACE OF DEATH:

(a) County Pulaski  
(b) City or town Waynesville, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Nevers Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.  
In this community lied on arrival  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Crawford  
(c) City or town Cuba, Missouri  
(If outside city or town limits, write "RURAL")  
(d) Street No. R. R. Star  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country No.

3. (a) PRINT FULL NAME August J. Emnitz

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Rosie 6. (c) Age of husband or wife if alive Dead years  
7. Birth date of deceased October 20 1870  
(Month) (Day) (Year)

8. AGE: Years 76 Months 3 Days 4 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business Owner

MOTHER FATHER { 12. Name Frederick Emnitz 9  
13. Birthplace Unavailable  
(City, town, or county) (State or foreign country)  
14. Maiden name Augusta Nellis  
15. Birthplace Cape Girardeau Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant John F. Seitz

(b) Address R. R. 3, Cuba, Missouri

17. (a) Burial (b) Date thereof 1-25-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation

18. (c) Signature of funeral director Shanklin Funeral Home

(b) Address Cuban Missouri

19. (a) 2/26/47 (b) Lawrence B. McClintock  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 22  
year 1947 hour 1 minute 45 A.M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him alive on January 22, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration \_\_\_\_\_

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

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

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

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

Of autopsy no

PHYSICIAN

Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION

22. If death was due to external causes, fill in the following: Accidental Cause

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence 1-22-47

(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?  
lied in ambulance on arrival at hospital

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

23. Signature R. B. Seiper Date signed 1/23/47

Address Richland Mo.

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

FEB 17 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.....

*Paul A. Shanklin*

....., Registered Apprentice No.....

working under my personal supervision.

*Paul A. Shanklin*

Signed.....

Licensed Embalmer No. *3472*

P. O. Address *Cuba, 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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. March

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH:**

(a) County Polaski

(b) City or town Washingtonville  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)

**3. (a) PRINT FULL NAME:** August Emmitz

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex ♂ 5. Color or race \_\_\_\_\_ 6. (a) Single, widowed, married, divorced \_\_\_\_\_

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

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: 76 Years 3 Months 1 Day (Less than one day) \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

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

**MOTHER FATHER**

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 \_\_\_\_\_ (Month) (Day) (Year)

(Burial, cremation, or removal)

(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 \_\_\_\_\_ year 1977 day \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Immediate cause of death \_\_\_\_\_

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

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

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

**PHYSICIAN**

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

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

✓

S-5789.