No. 2
-12-45
-17-39
X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 9 1947

Registration District No. 118

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8564

Primary Registration District No. 4118-P-5439

Registrar's No. 50

1. PLACE OF DEATH:

(a) County GASCONADE

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

(c) Name of hospital or institution: OWENSVILLE ROUTE 3 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution

In this community 9 YEARS (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County GASCONADE 37

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

(d) Street No. OWENSVILLE MO ROUTE 3
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME ROSE ANIELAK

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex FEMALE 1

5. Color or race WHITE

6. (a) Single, widowed, married, divorced WIDOWED 2

6. (b) Name of husband or wife WALTER ANIELAK

6. (c) Age of husband or wife if alive DEAD years

7. Birth date of deceased JULY (Month) 25 (Day) 1863 (Year)

8. AGE: Years 73 | Months 7 | Days 29 | If less than one day ____hr. ____min.

9. Birthplace SINSINNATI (City, town, or county) OHIO 1 (State or foreign country)

10. Usual occupation HOUSEWIFE 1

11. Industry or business

FATHER
12. Name JOHN MLYNARCZYK 1
13. Birthplace (City, town, or county) POLAND 1 (State or foreign country)

MOTHER
14. Maiden name CATHERINE CHLOPKOWIAK
15. Birthplace (City, town, or county) POLAND 4 (State or foreign country)

16. (a) Informant FRANK ANIELAK 1

(b) Address OWENSVILLE MO R.3

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MARSH 27-1947 (Month) (Day) (Year)

(c) Place: burial or cremation MT. OLIVE CEM. ST. LOUIS MO

18. (a) Signature of funeral director Milford H. Winter

(b) Address Owensville Mo

19. (a) 4-5-47 (Date received local registrar) (b) Dorothy Blackman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 24 year 47 hour 1 minute 30 P.M.

21. I hereby certify that I attended the deceased from March 19, 1947, to March 24, 1947; that I last saw her alive on March 22, 1947; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Acute coronary thrombosis	10 min
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death): Chronic Cholecystitis	25 yrs.

Major findings:
Of operations —
Of autopsy —

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 Paul D. Brewster (M.D. or Coroner)

Address Owensville, Mo Date signed 3-24-47

56 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,

District File Number 4-8-47

Date Filed

JUL 14 1954

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 Milford H. 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.