

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED OCT 19 1949

No. 300
10.48

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

36
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BIRTH NO.		REG. DIST. NO. <u>116</u>	PRIMARY REG. DIST. NO. <u>3020</u>	Registrar's No. <u>145</u>
1. PLACE OF DEATH a. COUNTY <u>Franklin</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Gasconade</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Washington</u> c. LENGTH OF STAY (in this place) <u>4 mo.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Owensville</u> <u>32</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Francis Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>10</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>Stanley</u> b. (Middle) <u>Jonas</u> c. (Last) <u>Jonas</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 8 1949</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>Nov. 11, 1883</u>	9. AGE (In years last birthday) <u>65</u> OF UNDER 1 YEAR Months <u>10</u> Days <u>27</u> IF UNDER 2 HRS. Hours <u>Min.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Clay Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clay mining</u>	11. BIRTHPLACE (State or foreign country) <u>Czechoslovakia</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>John Jonas</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Cuba</u>	14. NAME OF HUSBAND OR WIFE <u>Frances Jonas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>494-09-6704</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Joseph Jonas</u> ADDRESS <u>Owensville, Mo.</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, assthenia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Rt. Hemiplegia</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis-Advanced</u> DUE TO (c) <u>None</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos. 2 yrs.</u> <u>4500</u>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>4-12</u> , 19 <u>49</u> , to <u>10-8</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>10-7</u> , 19 <u>49</u> , and that death occurred at <u>7 pm.</u> , from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) <u>Paul A. Brennan, M.D.</u>		23b. ADDRESS <u>Owensville, Mo.</u>		23c. DATE SIGNED <u>10-10-49</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Oct. 11, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Catholic Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Near Owensville, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>Oct. 10, 1949</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>99</u> ADDRESS <u>Millard H.H. Winter OWENSVILLE</u>		

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
OCT 17 1949
District Health Officer No. 9,
District File Number.

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

Student Embalmer No.

working under my personal supervision.

Signed Malford W. A. Winter

Signed
Student Embalmer

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.