

DEC 11 1939

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. 4317

1. PLACE OF DEATH:

(a) County Jackson  
 (b) City or town Manassas city  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
15 E. Gen Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 day  
 (Specify whether  
 In this community: 12 days (Specify whether  
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Jackson  
 (c) City or town Manassas city  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 514 1/2 main  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME

J. E. Zack 2nd

3. (b) If veteran name war

unk

3. (c) Social Security No.

unk

4. Sex

M

5. Color or race W

6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife

\_\_\_\_\_

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

7. Birth date of deceased

March 12 1887  
 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>57</u>	<u>7</u>	<u>23</u>	_____ hr. _____ min.

9. Birthplace

Ill  
 (City, town, or county) (State or foreign country)

10. Usual occupation

none

11. Industry or business

7

12. Name

Joseph Zack

13. Birthplace

Austonia  
 (City, town, or county) (State or foreign country)

14. Maiden name

Anna Paperna

15. Birthplace

Austonia  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature

Richard Clark

(b) Address

15 E. Gen Hospital

17. (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

12-16-39  
 (Month) (Day) (Year)

(c) Place: burial or cremation

Gen Hosp

18. (a) Signature of funeral director

Wm A Johnson

(b) Address

15 E. Gen Hospital

19. (a)

12 1939  
 (Date received local registrar)

(b)

M. M. Crowe  
 (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 5  
 year 1939 hour 10 minute 55-PM

21. I hereby certify that I attended the deceased from 11-4-39, 1939, to 11-5-39, 1939;  
 that I last saw him live on 11-5-39, 1939;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Bright Pleural Effusion, Tuberculous Atelectasis, Interlobar  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions old coronary occlusion  
 (Include pregnancy within 3 months of death)

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

Of autopsy See above

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 P. J. De Marco (M.D. or other)  
 Address \_\_\_\_\_ Date signed \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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, above space should be left blank.**