

FILED MAR 5 - 1940
181

Registration District No. _____

Primary Registration District No. 5251

Registrar's No. _____

1. PLACE OF DEATH:

(a) County CHRISTIAN
(b) City or town RURAL POLK TOWNSHIP
(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 _____ years, months or days)

3. (a) PRINT FULL NAME AUGUST DONAT 530

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

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife EMMA DONAT 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased AUG 27 1862
(Month) (Day) (Year)

8. AGE: Years 77 Months 5 Days 20 If less than one day _____ hr. _____ min.

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

10. Usual occupation FARMER

11. Industry or business G

12. Name UNKNOWN

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name UNKNOWN

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant William Schoenack

(b) Address Billings Mo

17. (a) Burial (b) Date thereof Feb 17, 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Peter's Cemetery

18. (a) Signature of funeral director Ed Wallace

(b) Address Billings Mo 167

19. (a) Feb 19 1940 (b) F. N. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Christian
(c) City or town Billings Rural
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A? 51 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 16
year 1940 hour 10 minute 3 A.M.

21. I hereby certify that I attended the deceased from Jan 15 1940
to Feb 15 1940
that I last saw him alive on Feb 15 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Graciosa
Procto-pneumonia
Due to General arteriosclerosis

Due to Terminal infection

Other conditions (Include pregnancy within 3 months of death)

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 Frank Verord (M. D. or other) 1
Address Billings Mo Date signed 2-16-40

Duration 6 weeks 16 days
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 6,

District File Number 340-607

Date Filed MAR 4 1940

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.....

Everett R. Head

Registered Apprentice No.

working under my personal supervision.

Signed

Everett R. Head

Licensed Embalmer No. 4038

P. O. Address Billings, 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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **6294**
Registrar's No. _____

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **181**

Primary Registration District No. **3257**

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

1. PLACE OF DEATH:

(a) County **Christian**

(b) City or town **Park**
(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 _____
years, months or days

3. (a) PRINT FULL NAME **August Donat**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **m** 5. Color or race **w**

6. (a) Single, widowed, married, divorced **wid**

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: Years **77** Months **5** Days **20**
If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) If foreign born, how long in U. S. A.? _____ years.

20. DATE OF DEATH: Month **Feb** day **16**
year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, 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: **Pneumonia - Chronic repetitive**
Broncho Pneumonia
Due to **General Arterio Sclerosis**
Due to **Terminal Infection**

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: **121**
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? _____

While at work? _____
(Specify type of place)

(e) Means of injury _____

23. Signature **Frank Veroni** (M. D. or other) _____
Address **Billings** _____ Date signed _____

SUPPLEMENTAL

