

No. 2
5-43
5-17-39
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FILED JUN 11 1945

State File No.

Registration District No. 59

Primary Registration District No. 5218

Registrar's No. 78

1. PLACE OF DEATH:

(a) County Cass
(b) City or town Pleasant Hill, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: R.F.D. #2 Pleasant Hill, Mo.
(If not in hospital or institution, write "Home" or "Place")
(d) Length of stay: In hospital or institution 3 months (Specify whether years, months or days)
In this community 3 months (Specify whether years, months or days)

3. (a) PRINT FULL NAME Mary Okrazda
3. (b) If veteran, name war.....
3. (c) Social Security No.

4. Sex Female 5. Color or race ph
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Joseph Okrazda
6. (c) Age of husband or wife if alive 18 years (Day) (Year)
7. Birth date of deceased Dec 18 1862 (Month) (Day) (Year)

8. AGE: Years 82 Months 5 Days 6 If less than one day hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name Hayney Germany
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name.....
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Anna Meller

(b) Address Pleasant Hill Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 26 1945 (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director Mr C.L. Fawcett

(b) Address R.C. Mo
19. (a) May 25, 1945 (Date registered local registrar) (b) Margaret Talle (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 1923 Cleveland (If rural, give location)
(e) Citizen of foreign country? ! (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 24 year 1945 hour 12 minute 30 A. M.
21. I hereby certify that I attended the deceased from Mar. 10, 1945, to May 24, 1945; that I last saw her alive on May 15, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma body of pancreas Duration

Due to.....
Due to.....
Other conditions (include pregnancy within 3 months of death).....

Major findings: Of operations.....
Of autopsy.....
PHYSICIAN Hop
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) (c) Means of injury !
23. Signature M. Murray (M.D. or other)
Address Pleasant Hill Mo Date signed 5-24-45

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

1041

2570

EX 1

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.....

working under my personal supervision.

Registered Apprentice No.....

Signed.....

E. H. Nile

Licensed Embalmer No. 2570

P. O. Address. 100 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

Jay Jones
State File No. *may*
Registrar's No. *78*

Registration District No. *59* Primary Registration District No. *5218*

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

1. PLACE OF DEATH:
(a) County *Cass*
(b) City or town *Rural Big Creek Twp.*
(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) (Specify whether

3. (a) PRINT FULL NAME *Mary Ohrazda*
3. (b) If veteran, name war: *F* 3 (c) Social Security No. *3*

5. Color or race *W*
6. (a) Single, widowed, married, divorced *wid*
6. (b) Name of husband or wife: *dec 18*
6. (c) Age of husband or wife if alive *18*
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years *82* Months *5* Days *5* If less than one day hr. min.

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

10. Usual occupation *Home maker*

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director (b) Address

19. (a) (Date received local registrar) (b) *Margaret Volk* (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 _____ day _____ year _____ 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 _____
Due to _____
Due to _____

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 _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

Duration _____
PHYSICIAN
Underline the cause to which death should be charged statistically.

16581