

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

36288

**1. PLACE OF DEATH**

County Benton  
Township Williams  
City Mora

Registration District No. 59  
Primary Registration District No. 5094

File No. ....  
Registered No. 24  
St. .... Ward)

**2. FULL NAME** Catherine Jagels Mahnken

(a) Residence, No. .... St. .... Ward. ....

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Dick Mahnken

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2-15-1849

7. AGE 80 YEARS 9 MONTHS 9 DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work At Home (b) General nature of industry, business, or establishment in which employed (or employer). (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

10. NAME OF FATHER Henry Jagels

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

14. INFORMANT Henry Mahnken (Address) Ionia, R F D

15. FILED 12-2-29 Harry Bas REGISTRAR

**2 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-24-29 19

17. I HEREBY CERTIFY, That I attended deceased from Nov 22, 1929, to Nov 24, 1929 that I last saw her alive on Nov 24, 1929, and that death occurred, on the date stated above, at 5:00 A.M.

THE CAUSE OF DEATH: WAS AS FOLLOWS:

Arterio sclerosis  
122 B  
99 (duration) 15 yrs. mos. da.  
CONTRIBUTORY Intestinal obstruction (SECONDARY) (duration) yrs. mos. 2 da.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH.

19. DID AN OPERATION PRECEDE DEATH. No DATE OF ✓ WAS THERE AN AUTOPSY. No

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) C. H. Brady, M. D. Nov 26, 1929 (Address) Cole Camp Mo

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

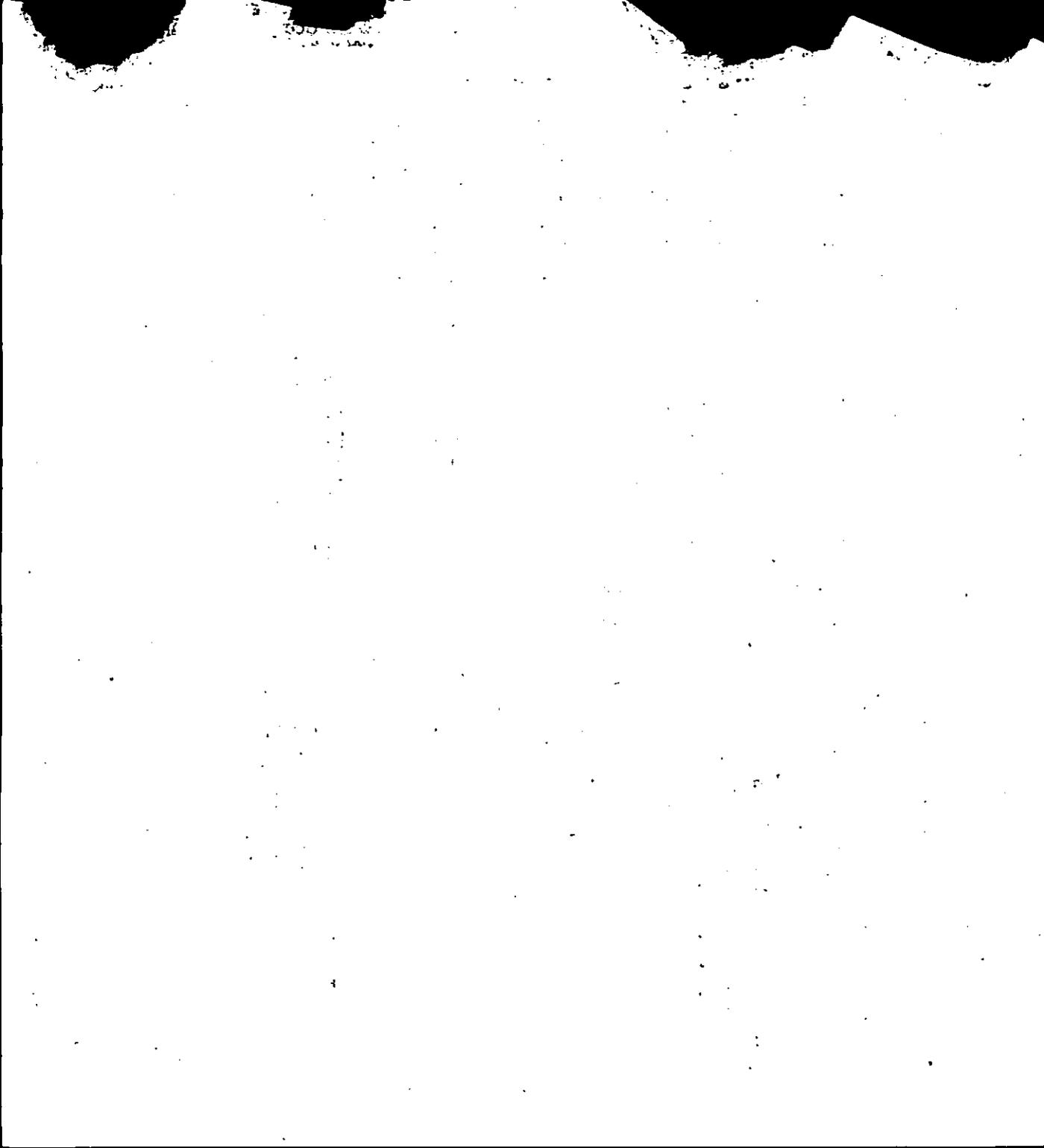
19. PLACE OF BURIAL, CREMATION, OR REMOVAL Memorial Park Cemetery DATE OF BURIAL 11-27-29

20. UNDERTAKER E L Eichhoff ADDRESS Cole Camp Mo

PHYSICIAN'S OCCUPATION IS NOT TO BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS NOT TO BE SUPPLIED. AGE SHOULD BE STATED.

262

18 1929



**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Benton  
Township Williamina  
City (No. ....) St. .... Ward)

Registration District No. 59  
Primary Registration District No. 3094

File No. ....  
Registered No. 24

**2. FULL NAME**

Catherine Jagels Mahnken

(a) Residence. No. .... St. .... Ward. ....  
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>m</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, .... hrs. or .... min.
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8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

**PARENTS**

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED 12-2-29 Harry Bay REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-24 1929

17. I HEREBY CERTIFY That I attended deceased from ..... 19..... to ..... 19..... that I last saw h. .... alive on ..... 19....., and that death occurred, on the date stated above, at .....

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

arteriosclerosis

(duration) 15 yrs. .... mos. .... ds.

CONTRIBUTORY (SECONDARY) arterial obstruction (heart impaction ????)

(duration) .... yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WHAT TEST CONFIRMED DIAGNOSIS? 118 B2

(Signed) ..... M. D.

, 19 (Address)

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state in plain terms, so that the CAUSE OF DEATH in plain terms. EXACT STATEMENT OF OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

5-36288

YOUTH CENTER  
1001 1/2 BROADWAY  
NEW YORK, N.Y.

TO: Mr. J. Edgar Hoover  
Director, FBI

FROM: Mr. [Name illegible]

DATE: [Date illegible]

RE: [Subject illegible]

Enclosed for the Bureau are [Number illegible] copies of [Document Name illegible]