

Registration District No. 1318

Primary Registration District No. 1003

Registrar's No. 2726

1. PLACE OF DEATH:

(a) County.....
(b) City or town. St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Park Lane Memorial Hospital
(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 Agnes Mollick

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

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

7. Birth date of deceased. about 1887
(Month) (Day) (Year)

8. AGE: Years abt - 55 Months Days If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business.....

MOTHER FATHER { 12. Name Unknown
13. Birthplace Unknown (City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Margaret Mollick

(b) Address Ashley, Illinois.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof. 9/15/42
(Month) (Day) (Year)

(c) Place: burial or cremation Ashley, Illinois.

18. (a) Signature of funeral director Albert H. Hoppe Inc

(b) Address 4700 Washington Blvd.,

19. (a) SEP 17 1942 (Date received local registrar) (b) J. H. Biedick (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County WAR.
(c) City or town Ashley R. R.
(If outside city or town limits, write "RURAL")
(d) Street No.....
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No) L
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 14
year 1942 hour 2 minute 40 M.

21. I hereby certify that I attended the deceased from 8-30-42 19... to 9-14-42 19...;

that I last saw her alive on 9-14-42 19...; and that death occurred on the date and hour stated above.

Immediate cause of death.....

Degenerative myocarditis
Due to toxic goiter

Due to.....

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

Major findings: 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: John J. Smith (M.D. or D.O.)
Address 4930 Lindbergh Date signed 9-15-42

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

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.....

J. G. Sullivan

Licensed Embalmer No..... *1122*

P.O. Address..... *City*

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.