

No. 2  
11-10-39  
-17-39  
X21492

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

41150

State File No.

FILED DEC 22 1943 / 49  
Registration District No.

Primary Registration District No. 1002

Registrar's No. 5052

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Marys Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 Weeks  
(Specify whether  
in this community 11 Years  
years, months or days)

8. (a) PRINT FULL NAME Jacob P. MANGRICH.

3. (b) If veteran, name war World War. 3. (c) Social Security No. 702-14-2825.

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

6. (b) Name of husband or wife Florence Mangrich 6. (c) Age of husband or wife if alive 43 years

7. Birth date of deceased January 4th 1898  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>45</u>	<u>10</u>	<u>26</u>	hr. min.

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

10. Usual occupation Accountant

11. Industry or business Missouri Pacific R.R.

MOTHER FATHER { 12. Name John Mangrich

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

14. Maiden name Catherine Adams

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

16. (a) Informant Florence Mangrich, (Wife)

(b) Address 2538 Van Brunt, K.C. Mo.

17. (a) Removal (b) Date thereof 12/1/43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Aurora Missouri

18. (a) Signature of funeral director Melody-McGilley

(b) Address K. C. Mo.

19. (a) 11-30-43 (b) D. E. Biron  
(Date received local registrar) (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. 2538 Van Brunt.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 30<sup>th</sup>  
year 1943 hour 7 minute 25 P.M.

21. I hereby certify that I attended the deceased from November 7  
1943, to November 30, 1943;  
that I last saw him alive on November 29, 1943;  
and that death occurred on the date and hour stated above.

Immediate cause of death Lymphoblastoma - mediastinal and retroperitoneal. (Nathan)  
Due to pending microscopic examination  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy See above (cause of death)

Duration

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 J. E. Cassidy (M. D. or other) \_\_\_\_\_  
Address 1002 Ogden Bldg Date signed 11-30-43

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

361

(Licensed Embalmer's Statement on Reverse Side) Kansas City, Mo

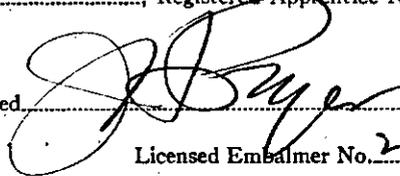
DEC 2 9 1940

**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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....



Licensed Embalmer No. 2999

P. O. Address..... K.C.

**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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No.

Jan  
5052

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(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 Jacob P. Mangrich  
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 m

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

7. Birth date of deceased Jan 4 (Month) (Day) (Year)

8. AGE: 45 Years 10 Months Days If less than one day min.

9. Birthplace ms. (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) (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) (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 2 Year 43 Day 3 Minute M.

21. I hereby certify that I attended the deceased from 19...  
that I saw him alive on 19...  
and that death occurred on the date and hour stated above.  
Immediate cause of death.

Probable granulosis lymphoblastosis  
Probably Hodgkin's disease with  
effusion retroperitoneum & mediastinum  
Lymphadenopathy. Splenomegaly  
Hodgkin's disease  
Complicated removal of lungs  
Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations  
Of autopsy see above  
448  
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 J. Cloutier (M. D. or other)  
Address 1002 Apple Bldg. Date signed 1-17-44

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

SUPPLEMENTARY

S-41156