

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **5024**

Regist. Dist. No. **42**

Primary Registration District No. **1000**

Registrar's No. **227**

1. PLACE OF DEATH:

(a) County **Buchanan**
(b) City or town **St Joseph**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2823 Sylvania St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 wks**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **John G. Agenstein**

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 **Married**
6. (b) Name of husband or wife **Elizabeth E** 6. (c) Age of husband or wife if alive **12** years
7. Birth date of deceased **Dec. 12 1867**
(Month) (Day) (Year)

8. AGE: Years **77** Months **2** Days **14** If less than one day hr. min.

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

10. Usual occupation **Retired Rural Mail Carrier**

11. Industry or business

12. Name **Unknown**
13. Birthplace **Switzerland**
(City, town, or county) (State or foreign country)
14. Maiden name **Susan** **Unknown**
15. Birthplace **Switzerland**
(City, town, or county) (State or foreign country)

16. (a) Informant **Elizabeth E. Agenstein**
(b) Address **St Joseph, Mo**
17. (a) **Burial** (b) Date thereof **3-1-45**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Memorial Park**

18. (a) Signature of funeral director **Fleeman & Son Inc**
(b) Address **St Joseph, Mo**
19. (a) **3-1-45** (b) **John J. Puck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Buchanan**
(c) City or town **St Joseph**
(If outside city or town limits, write "RURAL")
(d) Street No. **2823 Sylvania**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **26** year **1945** hour **7** minute **45 A.M.**
21. I hereby certify that I attended the deceased from **Feb 26 45** to **Feb 26 45**
not alive 19. **45**
that I last saw him alive on **Feb 26 45** and that death occurred on the date and hour stated above.

Immediate cause of death **Clinicaly acute dilatation of heart**
Due to **Coronary atherosclerosis**
Due to **Valvular lesion**

Other conditions (Include pregnancy within 8 months of death) **g2h**

Major findings: Of operations **No operation**
Of autopsy **No 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?

(Specify type of place)
While at work (e) Means of injury **Car**
23. Signature **John J. Puck** M.D. or other
Address **St Joseph, Mo** Date signed **Feb 26 45**

MAY 8 1945

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

Robert L. Gable

Licensed Embalmer No. 3308

P. O. Address St. Joseph, 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.