. S. No. 2
M—9-4-41
ev. 5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 22 1945

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 9134

Registration District No. 42 Primary Registration District No. 1 Registrar's No. 255

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: State Hospital No 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 days (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Buchanan
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 3416 Washington
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME AGNES LYNN
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F 1
5. Color or race W.
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife Single
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Mch 26 1891 (Month) (Day) (Year)

8. AGE: Years 53 Months 11 Days 17 If less than one day hr. min.

9. Birthplace Valley Falls Kansas (City, town, or county) (State or foreign country)
10. Usual occupation Musician
11. Industry or business
FATHER
12. Name not given
13. Birthplace ? (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Not given
15. Birthplace not given ? (City, town, or county) (State or foreign country)
16. (a) Informant Record Hospital
(b) Address St. Joseph Mo
17. (a) Cremated (Burial, cremation, or removal) (b) Date thereof 3-4-45 (Month) (Day) (Year)
(c) Place: burial or cremation K.C. Mo.
18. (a) Signature of funeral director O. Donnell
(b) Address K.C. Mo.
19. (a) 3-4-45 (Date received local registrar) (b) Helen I Fisher (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mch day 3 year 1945 hour 12-15 minute P M.
21. I hereby certify that I attended the deceased from 3-3, 1945 to 3-3, 1945 that I last saw him alive on 3-2, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
acute dilatation of Heart
Due to Chronic Myocarditis
Due to
Other conditions Schizophrenia
(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? (Specify type of place)
While at work? (e) Means of injury
23. Signature O E Salyer (M. D. or ~~other~~)
Address St Joseph Mo. Date signed 3/3/45

1377 (Licensed Embalmer's Statement on Reverse Side)

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.....

P. O. Address.....

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.