

FILED JAN 28 1946

Primary Registration District No. 1000

1. PLACE OF DEATH:

(a) County Buchanan Co.
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Missouri Methodist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days
(Specify whether years, months or days) 2 days
In this community _____

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME

Millie G. Kollar

3. (b) If veteran, name war None

3. (c) Social Security No. none

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife J. B. Kollar 6. (c) Age of husband or wife if alive 70 years
7. Birth date of deceased August 27 1884
(Month) (Day) (Year)

8. AGE: Years 61 Months 3 Days 8 If less than one day _____ hr. _____ min.

9. Birthplace Ray County Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER

12. Name Will Grunder
13. Birthplace Ray County Mo
(City, town, or county) (State or foreign country)
14. Maiden name Martha Tucker
15. Birthplace Ray County Mo
(City, town or county) (State or foreign country)

16. (a) Informant J. B. Kollar
(b) Address Agency Mo
17. (a) Burial (b) Date thereof DEC 8 - 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Union Cem. Br. Rick Mo

18. (a) Signature of funeral director N. A. Sullivan
(b) Address G. O. W. E. R.
19. (a) Dec. 7, 1945 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 5
year 1945 hour 9 minute 45 P. M.

21. I hereby certify that I attended the deceased from 3 yrs.
_____, 19____, to present, 19____;
that I last saw her alive on December 5, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Mitral disease
Coronary disease

Due to Hypertension
Arteriosclerosis 2 yrs.

Due to _____

Other conditions Ventral hernia
(Include pregnancy within 3 months of death)

Major findings:
Of operations None
Of autopsy None

Duration 2 yrs.
PHYSICIAN
Underline the cause to which death should be charged statistically.

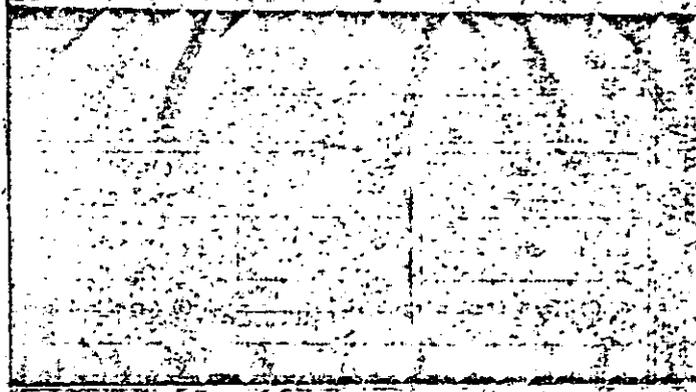
22. If death was due to external causes, fill in the following:

(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? _____ (c) Means of injury _____
23. Signature [Signature] M. D. or other MD
Address 218 N. 4th ST. JOSEPH Date signed 12/6

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

JAN 16 1948



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.....

H. A. Sullivan

Licensed Embalmer No.....

1738

P. O. Address.....

Lawrence, Mass.

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.