

**FILED MAY 12 1946**

Registration District No. **1000**

Primary Registration District No. **1000**

**1. PLACE OF DEATH:**

(a) County **Buchanan St. Joseph-**  
(b) City or town  
(c) Name of hospital or institution: **Missouri Methodist Hospital**  
(d) Length of stay: In hospital or institution **8 weeks**  
In this community **Most of her life.**

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **Missouri.** (b) County **Buchanan**  
(c) City or town **St. Joseph**  
(d) Street No. **917 South 10th. Street**  
(e) Citizen of foreign country? **NO**

3. (a) PRINT FULL NAME **MAGGIE DENIER.**

3. (b) If veteran, name war **NO** 3. (c) Social Security No. **491-28-0167**

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

6. (b) Name of husband or wife **William Denier** 6. (c) Age of husband or wife if alive **56**  
**August 14th. 1885**

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

8. AGE: Years **60** Months **8** Days **11** If less than one day hr. min.

9. Birthplace **Troy, Kansas.** (State or foreign country) **Housewife.**

10. Usual occupation

11. Industry or business

MOTHER FATHER { 12. Name **George W. Culp**  
13. Birthplace **Troy, Kansas.**  
14. Maiden name **Allice Briscoe**  
15. Birthplace **PLEASANT HILL? MO.**

16. (a) Informant **William Denier.**  
(b) Address **917 South 10th. Street.**

17. (a) **Burial** (b) Date thereof **4-29-46**  
(c) Place: burial or cremation **Mt. Auburn Cemetery**

18. (a) Signature of funeral director **Mrs. E. P. Sidenfaden**  
(b) Address **602 South 10th Street.**

19. (a) **May 2, 1946** (b) **[Signature]**  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Month **April** 25th. 1946  
year **1946** hour **9** minute **55** P. M.

21. I hereby certify that I attended the deceased from **March 28,**  
**1946** to **April 25,**  
that I last saw her alive on **April 25,**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Cronic Bilateral Pyelocystitis**  
Duration **2 mos.**  
Due to **Cronic obstruction at visical neck** 10 yrs

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 **[Signature]** (M. D. or other)  
Address **St. Joseph** Date signed **4/23/46**

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

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**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 *Mollie E. Sidenfaden Fox*

Licensed Embalmer No. *4235*

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.**