

FILED MAY 16 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

14938

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 531

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph, Wash.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph, Mo.</u>	
c. LENGTH OF STAY (in this place) <u>25 Days</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>809 South 16th Street</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Agnes</u>	b. (Middle) <u>Louisa</u>	c. (Last) <u>Mollinger</u>	4. DATE OF DEATH (Month) (Day) (Year)	<u>May</u>	<u>5</u>	<u>1949</u>
-------------------------------------	-------------------------	---------------------------	----------------------------	---------------------------------------	------------	----------	-------------

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 21, 1885</u>	9. AGE (In years last birthday) <u>64</u>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 1 MIN. Min.
----------------------	-------------------------------	---	--	---	------------------------	----------------------	------------------------	----------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady &amp; Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Frankfort Kansas</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
--	-----------------------------------	---	--

13a. FATHER'S NAME <u>Edward Garich</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Homan</u>	14. NAME OF HUSBAND OR WIFE <u>Matt</u>
---	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknowns) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>491-09-7444</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mr Matt Mollinger</u>	ADDRESS <u>809 South 16th.</u>
---	--	--	--------------------------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Leukopenic Leukemia</u>		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES  Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS  Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	----------------------------------	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
--	--	----------------------------

22. I hereby certify that I attended the deceased from 3-18, 1948, to 5-5, 1949, that I last saw the deceased alive on 5-5, 1949, and that death occurred at 8:40A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Louis S. Neundorff, M.D.</u>	23b. ADDRESS <u>St. Joseph Mo. 907 Edmund Street</u>	23c. DATE SIGNED <u>5-5-49.</u>
--	--	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>5/9/1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo.</u>
---	---------------------------	--	--

DATE REC'D BY LOCAL REG. <u>May 12, 1949</u>	REGISTRAR'S SIGNATURE <u>G. L. Jenkins</u>	382	25. FUNERAL DIRECTOR'S SIGNATURE <u>Norman M. Sidenfaden</u>	ADDRESS <u>1802 Union St.</u>
--	--	-----	--	-------------------------------

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

**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.....

..... Student Embalmer No. ....  
working under my personal supervision.

Student .....  
Student Embalmer

Signed Robert H. 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.