

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-012400

STATE FILE NUMBER

464

FILED MAY 11 1959

Registration District No.

042

Primary Registration District No.

1000

Registrar's No.

300

1-57

1. PLACE OF DEATH a. COUNTY Buchanan			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before permission) a. STATE Missouri b. COUNTY Buchanan		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 838 South 19th		Length of stay in lb Life	d. STREET ADDRESS (If outside, give location) 838 South 19th		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last JOHN MOLLUS			4. DATE OF DEATH Month Day Year May 1 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5, 1891	9. AGE (In years last birthday) 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. (4) Policeman		10b. KIND OF BUSINESS OR INDUSTRY City Police Dept.	11. BIRTHPLACE (City and state or country) St. Joseph, Mo.		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Peter Mollus		13b. MOTHER'S MAIDEN NAME Anna Gonaga		14. NAME OF HUSBAND OR WIFE Catherine Mollus	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 491-24-9067		17. INFORMANT Catherine Mollus Address 838 So. 19th City	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident Arteriosclerosis Gen. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Myocardial Insufficiency					INTERVAL BETWEEN ONSET AND DEATH Sudden
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 331X			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from May 10, 1955 to May 1, 1959 and last saw him alive on May 1, 1959 Death occurred at 9:00 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Robert W. Kleber, M.D.			22b. ADDRESS St. Joseph, Mo		22c. DATE SIGNED 5-3-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 4, 1959	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or country) (State) St. Joseph, Mo.
24. FUNERAL DIRECTOR H.O. Sidenfaden & Son		ADDRESS St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. May 7, 1959	26. REGISTRAR'S SIGNATURE Mrs. Clark Standell

All diseases in Part I must be causally related.

Dr. Robert W. Kleber

MEDICAL CERTIFICATION USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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
Signature of Student Embalmer

Signed *Robert H. Gypke*
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.