FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED NOV 29 1948

Registration District No. 42

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1000

State File No. 35746

Registrar's No. 1256

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Joseph Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 22 Days (Specify whether
In this community 67 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan 11

(c) City or town St. Joseph, Mo. 1
(If outside city or town limits, write "RURAL")

(d) Street No. 816 South 19th St. 7
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME Agnes Worman

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female 1

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed 2

6. (b) Name of husband or wife Fred

6. (c) Age of husband or wife if alive years

7. Birth date of deceased June (Month) 16 (Day) 1855 (Year)

8. AGE: Years 93 Months 5 Days 6 If less than one day hr. min.

9. Birthplace Haverbeck Germany 4
(City, town, or county) (State or foreign country)

10. Usual occupation House Wife

11. Industry or business

FATHER
12. Name Herman Sandinan
13. Birthplace Unknown Germany 4
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown Unknown
15. Birthplace Unknown Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant L.B.Worman
(b) Address 816 South 19th St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-24-1948 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Olivet Cemetery

18. (a) Signature of funeral director Herman W. Sidenfaden
(b) Address 1802 Union, St. Joseph, Mo.

19. (a) 11-24-48 (Date received local registrar) (b) E. C. Jenkins (Registrar's signature) 582

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 22
year 1948 hour 2 minute 47 A.M.

21. I hereby certify that I attended the deceased from 10-30-1948 to 11-22-1948
that I last saw her alive on 11-21-48 1948
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Acute Heart Failure	4 hrs
Due to: Arteriosclerotic Heart disease	?
Due to: Fracture to Left Femur at neck	25 days
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy 186 18

PHYSICIAN
Underline the cause of 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) 0
While at work? (e) Means of injury

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED 131

23. Signature Wm B. Rost (M. D. or other) MD
Address 510 Carby Bldg Date signed 11-22-48

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side) St. Joseph, Mo.

PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

NOV 30 1940

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 Elmer Thomas

Licensed Embalmer No. 2640

P. O. Address St. Joseph Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

o. 2B
-3-45
X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Dee

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1256

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:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Agnes Worman

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced Wid

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased June (Month) 16 (Day) 1855 (Year)

8. AGE: Years 93 Months 5 Days 6 If less than one day hr. min.

9. Birthplace (City, town, or county) Germany (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 22
year 1948 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 186 18
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) Accident

(b) Date of occurrence Oct 30, 1948

(c) Where did injury occur? St Joseph (City or town) Buchanan (County) Mo (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
At home. Fell down stairs (Specify type of place)
While at work? No (e) Means of injury Fall

23. Signature Wm B. Rost MD (M. D. or other)
Address 510 Carby Bldg Date signed 12-2-48

SUPPLEMENTARY

S-35746