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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 29 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **17300**
Registrar's No. **2209**

Registration District No. **149** Primary Registration District No. **1002**

1. PLACE OF DEATH:
(a) County **Jackson**
(b) City or town **Kansas City**
(c) Name of hospital or institution **St Joseph Hospital**
(d) Length of stay: In hospital or institution **33 days**
In this community **33 days**

3. (a) PRINT/FULL NAME **William Stephen Arden**
3. (b) If veteran, name war **no** 3. (c) Social Security No. **no**
4. Sex **Male** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **April 16 1947**

8. AGE: Years **0** Months **0** Days **33** If less than one day _____ hr. _____ min.

9. Birthplace **Kansas City mo**
(City, town, or county) (State or foreign country)

10. Usual occupation **none**

11. Industry or business _____

MOTHER, FATHER
12. Name **Stephen Arden**
13. Birthplace **Pa**
14. Maiden name **Helen Waddle**
15. Birthplace **Kansas City mo**

16. (a) Informant **Stephen Arden**
(b) Address **2901 Wallace**

17. (a) **Burial** (b) Date thereof **May 21-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Floral Hill**
(d) Signature of funeral director **Mrs C L Foster**
(e) Address **918 Brooklyn**
5-20-47 (b) **Sheldine Palma**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(d) Street No. **2901 Wallace**
(e) Citizen of foreign country? **no**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **May** day **19** year **1947** hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____
that I last saw him alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death **Bronchitis Pneumonia**
Diphtheria Larynx
Due to _____

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

Major findings: **107**
Of operations _____
Of autopsy _____

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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place) _____
While at _____ (e) Means of injury _____
23. Signature **Sheldine Palma** (M. D. or other) _____
Address **St Joseph Hospital** Date signed **May 21 47**

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

1874

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 *Dean Owens*

Licensed Embalmer No. *4280*

P. O. Address *R. E. Brooklyn, Me.*

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

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

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2209

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Joseph Hosp
(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 Mo (b) County Jackson
(c) City or town Kansas City, Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 1901 Wallace
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME William Stephen Arden

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex _____ 5. Color or race _____ 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

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

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

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace (City, town, or county) _____ (State or foreign country) _____

14. Maiden name _____

15. Birthplace (City, town, or county) _____ (State or foreign country) _____

16. (a) Informant _____

(b) Address 1901 Wallace

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) 5-20-47 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____ Year _____ Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____

Due to _____

Due to _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

17300