No. 2
-1/47
-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED AUG 30 1947
Registration District No. 42

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 26810

Primary Registration District No. 1000

Registrar's No. 1003

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: Mo. Methodist Hosp. (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 3 days (Specify whether years, months or days)
In this community: 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Worth 113
(c) City or town: Grant City (If outside city or town limits, write "RURAL")
(d) Street No.: Grant City, Mo.. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: Ara Etta Foland
3. (b) If veteran, name war: No
3. (c) Social Security No.: None
4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Gash L. Foland
6. (c) Age of husband or wife if alive: 84 years
7. Birth date of deceased: October (Month) 20 (Day) 1866 (Year)

8. AGE:	Years	Months	Days	If less than one day
	80	9	25	hr. min.

9. Birthplace: Unknown (City, town, or county) Illinois (State or foreign country)
10. Usual occupation: At home
11. Industry or business: At home
MOTHER FATHER
12. Name: Richard Swank
13. Birthplace: Unknown (City, town, or county) Illinois (State or foreign country)
14. Maiden name: Amanda Blake
15. Birthplace: Unknown (City, town, or county) Indiana (State or foreign country)
16. (a) Informant: Gash L. Foland
(b) Address: Grant City, Mo..
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 8/15/47 (Month) (Day) (Year)
(c) Place: burial or cremation: Grant City, Mo.
18. (a) Signature of funeral director: Heaton-Rowman
(b) Address: St. Joseph, Mo.
19. (a) 8-22-47 (Date received local registrar) (b) E. C. Jenkins (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: August day: 15 year: 1947 hour: 8 minute: 10 A.M.
21. I hereby certify that I attended the deceased from 8-12, 1947 to 8/15, 1947 that I last saw her alive on 8/14/47, 19.... and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cardiac Failure	2 da
Due to: Fract. left Hip	4 "
Due to: Fall in home	
Other conditions (Include pregnancy within 3 months of death): Pulmonary edema	
Major findings: Of operations: none	
Of autopsy: none	

PHYSICIAN — Underline the cause of which death should be charged statistically.

22. If death was due to external causes, fill in the following: 113
(a) Accident, suicide, or homicide (specify): accident
(b) Date of occurrence: August 12, 1947
(c) Where did injury occur? Grant City (City or town) (County) Mo. (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? home (Specify type of place)
While at work? no (e) Means of injury: fall
23. Signature: J. Kulowski (M. D. or other)
Address: St. Joseph, Mo. Date signed: 8/15/47

Jefferson City Printing Co.
(Licensed Embalmer's Statement on Reverse Side)

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~~ William Spalding, Registered Apprentice No. 28, working under my personal supervision.

Signed Eugene Wood

Licensed Embalmer No. 3804

P. O. Address 319 So. 10th St. Joseph, M

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.