No. 2
-9-4-41
5-17-39
X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 9 1948

Registration District No. 42

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 28885

Primary Registration District No. 1000

Registrar's No. 1050

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: State Hospital #2 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 19 yrs 10 mo 23 days (Specify whether
In this community 19 yrs 10 mo 23 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

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

(d) Street No. 3535 Brooklyn 9
(If rural, give location)

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

If yes, name country None!

3. (a) PRINT FULL NAME ANNA MAY AREND

3. (b) If veteran, name war No

3. (c) Social Security No. no

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife none

6. (c) Age of husband or wife if alive none years

7. Birth date of deceased October (Month) 30 (Day) 1894 (Year)

8. AGE: Years 53 Months 11 Days 1 If less than one day hr. min.

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

10. Usual occupation none

11. Industry or business none

FATHER
12. Name Louis Arand
13. Birthplace La Grange (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Cora Willis
15. Birthplace Rowls County (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Cora Willis
(b) Address 3523 Agnes St. Kansas City Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct. 1, 1948 (Month) (Day) (Year)
(c) Place: burial or cremation K. C., Missouri

18. (a) Signature of funeral director Walter Meierhoffer
(b) Address 1946 Colhoun St., St. Joseph, Mo.

19. (a) 10-4-48 (Date received local registrar) (b) C. C. Jenkins (Registrar's signature) 382

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month ~~August~~ OCTOBER day 1st
year 1948 hour 12 10 minute P M.

21. I hereby certify that I attended the deceased from August 1, 1948, to October 1, 1948; that I last saw her alive on Oct 1, 1948; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic Myocarditis	2yrs.
Due to	
Due to	
Other conditions Bronchial Asthma (Include pregnancy within 3 months of death)	40yrs.

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) none

(b) Date of occurrence none

(c) Where did injury occur? none (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? none (Specify type of place)

While at work? none (e) Means of injury none

23. Signature Forrest Thomas (M. D. ~~[illegible]~~)
Address St. Joseph Mo Date signed 10-1-48

(Licensed Embalmer's Statement on Reverse Side) State Hospital #2

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. H280

P. O. Address K. C., Mo.

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

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