V. S. No. 2
OM—8-43
5-17-39

FILED SEP 4 1945

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

26928

State File No.

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 902

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

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:
215 West Augusta
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 5 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 215 West Augusta
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Anna Blage VanDoren
3. (b) If veteran, name war none
3. (c) Social Security No. none
4. Sex female
5. Color or race white
6. (a) Single, widowed, married, divorced widow
6. (b) Name of husband or wife A
6. (c) Age of husband or wife if alive years
7. Birth date of deceased December (Month) 29 (Day) 1857 (Year)

8. AGE:	Years	Months	Days	If less than one day
	87	7	21	hr. min.

9. Birthplace Decatur (City, town, or county) Illinois (State or foreign country)
10. Usual occupation at home
11. Industry or business
FATHER
12. Name unknown
13. Birthplace unknown (City, town, or county) unknown (State or foreign country)
MOTHER
14. Maiden name Samira E. Boswell
15. Birthplace unknown (City, town, or county) unknown (State or foreign country)
16. (a) Informant Mrs. Leota Silcott
(b) Address 215 West Augusta
17. (a) burial (Burial, cremation, or removal) (b) Date thereof 8/22/45 (Month) (Day) (Year)
(c) Place: burial or cremation Ashland Cemetery
18. (a) Signature of funeral director Heaton Bethle & Bowman
(b) Address 319 South 10th
19. (a) 8/22/45 (Date received local registrar) (b) Helen I. Fiehle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 20
year 1945 hour 6 minute P M.
21. I hereby certify that I attended the deceased from August 17, 1945, to August 17, 1945;
that I last saw her alive on August 17th, 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
bronchitis	2 wks
diahhrea	3-4 days
Due to	
Due to	
Other conditions Arteriosclerosis (Include pregnancy within 3 months of death)	10 years

Major findings:
Of operations no
Of autopsy no

106

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) no
(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)
While at work? (e) Means of injury

23. Signature Charles H. Werner (M. D. or other) M.D.
Address Social Welfare Board Date signed 8/22/45

1377 (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 _____, Registered Apprentice No. _____, working under my personal supervision.

Signed Gerald I Wade

Licensed Embalmer No. 4172

P. O. Address St Joseph

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.