

FILED JAN 16 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

267

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 37

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St Joseph</u>		c. LENGTH OF STAY (in this place) <u>18yrs 5mo 12dy</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		d. STREET ADDRESS (If rural, give location) <u>610 Powell St.</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital #2</u>			3. NAME OF DECEASED (Type or Print) a. (First) <u>ANNA</u> b. (Middle) <u>—</u> c. (Last) <u>JONES</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Black</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Unknown</u>	9. AGE (in years last birthday) <u>69yrs</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>January 8 1949</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>No</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Arthur Larkin S. 610 Powell St. St. Joseph Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Myocarditis</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>1yr.</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>592</u>			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>NO</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>St. Joseph Mo.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>↓</u>			
22. I hereby certify that I attended the deceased from <u>Dec 1, 1948</u> , to <u>Jan 8, 1949</u> , that I last saw the deceased alive on <u>Jan 8, 1949</u> , and that death occurred at <u>205 P. m.</u> , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <u>Albert A. Almada M.D.</u>		23b. ADDRESS <u>State Hospital #2 St. Joseph Mo.</u>		23c. DATE SIGNED <u>1/8/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>Jan. 10, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>School of Osteopathy</u>	24d. LOCATION (City, town, or county) (State) <u>Kirksville, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>Jan. 12, 1949</u>	REGISTRAR'S SIGNATURE <u>E. G. Jenkins</u>	382	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Wm. H. Alexander, St. Joseph, Mo.</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Student Embalmer

Signed Wm. H. Alexander

Licensed Embalmer No. 4450

P. O. Address St. Joseph, Mo.

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.