

FILED SEP 11 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26071

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 1009

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1713 Bellevue St.		d. STREET ADDRESS (If rural, give location) 1713 Bellevue Street	

3. NAME OF DECEASED (Type or Print) a. (First) Anna b. (Middle) Hadorn c. (Last) Hadorn			4. DATE OF DEATH (Month) (Day) (Year) Sept. 5, 1950		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH May ? 1866	9. AGE (In years last birthday) 84	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife	10b. KIND OF BUSINESS OR INDUSTRY Unk.	11. BIRTHPLACE (State or foreign country) Unk. Hungary 4	12. CITIZEN OF WHAT COUNTRY? U.S.A
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13a. FATHER'S NAME John Myers	13b. MOTHER'S MAIDEN NAME Anna Meyers	14. NAME OF HUSBAND OR WIFE John
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	17. INFORMANT'S SIGNATURE OR NAME Mrs Helen Michel	ADDRESS 1801 Bellevue
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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		INTERVAL BETWEEN ONSET AND DEATH unknown n n 443X
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocardial Insufficiency		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Hypertension DUE TO (c) Arteriosclerosis General		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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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?
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22. I hereby certify that I attended the deceased from Feb 4, 1950, to Sept 5, 1950, that I last saw the deceased alive on Sept 5, 1950, and that death occurred at 10:30A., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Gustav Hain	23b. ADDRESS M. D. Kirkpatrick Bldg St. Joseph, Mo.	23c. DATE SIGNED 9-6-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9-7-1950	24c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	24d. LOCATION (City, town, or county) (State) St. Joseph, Mo.
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DATE REC'D BY LOCAL REG. Sept 8, 1950	REGISTRAR'S SIGNATURE E. C. Jenkins 382	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Herman W. Biedenbach 1802 Union St
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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.

Signed _____

Ernest Rhoads

Signed _____

Student Embalmer

Licensed Embalmer No. 2640

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.