

FILED MAR 25 1957

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 9760

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 280

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|--|----------------------------------|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Buchanan | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Buchanan | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN St. Joseph 01170 | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Josephs Hospital | | Length of stay in 1b | d. STREET ADDRESS 6704 Mack St. | | (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) Anna Wolney | | | First | Middle | Last |
| 4. DATE OF DEATH March 9, 1957 | | | Month | Day | Year |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 21, 1870 | 9. AGE (In years last birthday) 86 | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper | | 10b. KIND OF BUSINESS OR INDUSTRY Home | 11. BIRTHPLACE (City and state or country) Waco, Texas | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME John Habernale | | | 14. MOTHER'S MAIDEN NAME Theresa ? | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | 17. INFORMANT Mrs. Joseph Sanger, St. Joseph, Mo. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 day |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | DUE TO (b) _____ |
| DUE TO (c) _____ | | | | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m. | | | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | |
| 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION | | 20g. COUNTY STATE | |
| 21. I attended the deceased from 3/5/57 to 3/9/57 and last saw her alive on 3/8/57 Death occurred at 12:15 p m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE Arnell Henry M.D. | | | 22b. ADDRESS Tootle Building St. Joseph, Mo. | | 22c. DATE SIGNED 3/10/57 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 3-11-57 | 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | | 23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri | |
| 24. FUNERAL DIRECTOR John Rupp | | ADDRESS St. Joseph, Mo. | 25. DATE RECD. BY LOCAL REG. Mar. 18, 1957 | 26. REGISTRAR'S SIGNATURE Kathleen M. Allison | |

(Licensed Embalmer's Statement on Reverse Side)

with, self, fare, public, advice

100-56

Diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. If symptoms are abnormal, doctor, coroner, etc. must use only standard nomenclature in their reports. No symptoms are to be written in Part I unless they are casually related. Coroner cannot certify to a death due to natural causes. If symptoms are abnormal, doctor, coroner, etc. must use only standard nomenclature in their reports. No symptoms are to be written in Part I unless they are casually related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1850

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, ~~on~~....., Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *John E. Rupp*

Licensed Embalmer No. *39*

P. O. Address *St. Joseph*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.