WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Kinney

Township Bogard

or

Village

or

City (NO. St.; Ward)

Registration District No. 353 File No. X36844a

Primary Registration District No. 548573 Registered No. 93

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Geo B. Arbaugh

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Male	Caucasian	Single

DATE OF BIRTH August (Month) (Day), 1841 (Year)

AGE August 74 yrs. — mos. — ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Gen Farm work

BIRTHPLACE (City or town, State or foreign country) Pittsylvania Co Va.

PARENTS

NAME OF FATHER Jacob Arbaugh

BIRTHPLACE OF FATHER (City or town, State or foreign country) Va

MAIDEN NAME OF MOTHER Hannah Brower

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Va.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed Dec 27 1915 H. C. Smith REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH December (Month) 20 (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 13, 1915, to Dec 20, 1915, that I last saw h[illegible] alive on Dec 20, 1915, and that death occurred, on the date stated above, at 9:30 p.m.

The CAUSE OF DEATH* was as follows:

Colon Carcinoma

11A

10A (Duration) yrs. mos. 5 ds.

Contributory (SECONDARY) La Grippe

(Duration) yrs. mos. 8 ds.

(Signed) J. S. McDonald M. D.

Dec 21 1915 (Address) Ulrich Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death? at place of Death

Former or usual residence

PLACE OF BURIAL OR REMOVAL Hendrick Cemetery

DATE OF BURIAL Dec 21 1915

UNDERTAKER H. C. Smith

ADDRESS Ulrich Mo

PLACE OF DEATH

County.....

Township.....
or
Village.....
or
City.....

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No..... File No.....

Primary Registration District No..... Registered No.....

(NO..... .....St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., 1..... (Month) (Day) (Year)

AGE

.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ....., 191....., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., 191.....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191....., that I last saw h..... alive on ....., 191....., and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs.....mos.....ds.

Contributory.....
(SECONDARY)

.....(Duration).....yrs.....mos.....ds.

(Signed)..... M. D.

....., 191..... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
UNDERTAKER	ADDRESS

same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria*