

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

PLACE OF DEATH
County Camden
Township Camden
or
Village
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 117 File No. 16352-9
Primary Registration District No. 5167 Registered No. _____

FULL NAME Dorothy Arnold

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

PERSONAL AND STATISTICAL PARTICULARS			
SEX <u>Female</u>	COLOR OR RACE <u>W</u>	SINGLE MARRIED <u>Widowed</u> WIDOWED OR DIVORCED (Write the word)	
DATE OF BIRTH <u>Aug 2, 1835</u> (Month) (Day) (Year)			
AGE <u>82 9 27</u> yrs. mos. ds.		If LESS than 1 day, ____ hrs. or ____ min.?	
OCCUPATION (a) Trade, profession, or particular kind of work <u>none</u> (b) General nature of industry, business, or establishment in which employed (or employer)			
BIRTHPLACE (City or town, State or foreign country) <u>Germany</u>			
PARENTS	NAME OF FATHER <u>John Schwartz</u>		
	BIRTHPLACE OF FATHER <u>Germany</u> (City or town, State or foreign country)		
	MAIDEN NAME OF MOTHER <u>Robert</u>		
	BIRTHPLACE OF MOTHER <u>Germany</u> (City or town, State or foreign country)		

MEDICAL CERTIFICATE OF DEATH			
DATE OF DEATH <u>Mar, 29, 1918</u> (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 4 a m.

The CAUSE OF DEATH* was as follows:
Articular Rheumatism
57A Chronic
Had not treated her 6 months prior to death
(Duration) ____ yrs. ____ mos. ____ ds.
Contributory _____
(SECONDARY) _____
(Duration) ____ yrs. ____ mos. ____ ds.
(Signed) Geo. W. Moore M. D.
Jan 6, 1918 (Address) Linn Creek 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? _____
Former or usual residence _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G. A. Arnold
(ADDRESS) Linn Creek Mo
Filed Jan-6 1918 REGISTRAR

PLACE OF BURIAL OR REMOVAL <u>Arnold Cemetery</u>	DATE OF BURIAL <u>Mar. 31, 1918</u>
UNDERTAKER <u>no</u>	ADDRESS _____

PLACE OF DEATH

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

County.....

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

Registration District No. File No.

Primary Registration District No. Registered No.

City..... (NO. St.; Ward) (If death occur hospital or his give its NAME, of street and num

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX.....

COLOR OR RACE.....

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word.)

DATE OF BIRTH..... (Month)....., 191....., (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).....

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

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

I HEREBY CERTIFY, that I attended deceased

....., 191....., to....., 191....., that I last saw h..... alive on....., 191....., and that death occurred, on the date stated above, at.....

The CAUSE OF DEATH* was as follows:

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

Contributory

(SECONDARY)

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

(Signed).....

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

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENT RECENT RESIDENTS)

At place of death..... yrs. mos. ds. In the State..... yrs. mos. Where was disease contracted if not at place of death?

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS