

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

Do not use this space.

17683

1. PLACE OF DEATH

County Lewis
Township Salem
City Lewistown (No. _____)

Registration District No. 486
Primary Registration District No. 5248

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME Pheobe Coddington Arnold

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF William Arnold.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 30. 1841

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
87 4 5

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home,
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) New York City.
(STATE OR COUNTRY) N.Y.

10. NAME OF FATHER James Richardson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) N.Y.
(STATE OR COUNTRY) N.Y.

12. MAIDEN NAME OF MOTHER Charlotte Wood.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) N.Y.
(STATE OR COUNTRY) N.Y.

14. INFORMANT James Coddington
(Address) Lewistown, Missouri

15. FILED May 10 1928 Alvin T. Neal, M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

15. DATE OF DEATH (MONTH, DAY AND YEAR) May 25 1928

17. I HEREBY CERTIFY, That I attended deceased from May 20, 1928, to May 25, 1928
that I last saw her alive on May 25, 1928, and that death occurred, on the date stated above, at 2:45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Intestinal Obstruction
122B (duration) yrs. mos. da.

CONTRIBUTORY Acute obstruction (SECONDARY)
of bowels (duration) yrs. mos. 5 da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

0 DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) Geo. R. Rames M.D.

, 19 (Address) Ewing Mo

*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Lewistown, Missouri DATE OF BURIAL 5.26 1928

20. UNDERTAKER James A. Coles ADDRESS Lewistown, Mo.

PHYSICIANS should state CAUSE OF OCCUPATION is very important.

1. [REDACTED]

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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Keyes
Township Galena
City Phoebe Coddington Arnold

Registration District No. 483-
Primary Registration District No. 5648

File No.
Registered No.
St. Ward)

2. FULL NAME

(a) Residence. No. St. Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) W

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14.

INFORMANT (Address)

15.

FILED Aug 16 28 Alvin Neal REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 25 1928

17. I HEREBY CERTIFY That I attended deceased from, 19...., to, 19...., that I last saw him alive on, 19...., and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Chronic Intestinal Obstruction
cause unknown
unknown cause
CONTRIBUTORY (SECONDARY) Acute Obstruction of bowels

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH:

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed), M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

N. B. - Every item of information should be carefully supplied. OF should state EXACTLY. PHYSICIANS & ALL CAUSE OF DEATH in plain terms, so that it may be properly stated. FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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