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

Do not use this space. 14465

MAY 25 1929

1. PLACE OF DEATH

County Henry — Registration District No. 14

Township X — Primary Registration District No. 43-17

City Windsor (No. ..., St., Ward)

File No. — Registered No. 14

2. FULL NAME Deusilla Ann Arnold

(a) Residence. No. 301 E. Benton St., Ward. (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. If Married, Widowed, or Divorced HUSBAND of (or) WIFE of E.C.Aronld

6. DATE OF BIRTH (month, day and year) March 6, 1848

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
81	1	21	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

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

(c) Name of employer

9. BIRTHPLACE (city or town) Windsor (State or country) Missouri

PARENTS

10. NAME OF FATHER B.F.Goodwin

11. BIRTHPLACE OF FATHER (city or town) Hopkinsville (State or country) Kentucky

12. MAIDEN NAME OF MOTHER Elisabeth Janenlow

13. BIRTHPLACE OF MOTHER (city or town) Hopkinsville (State or country) Kentucky

14. INFORMANT Mrs Warren (Address) Windsor Mo.

15. FILED Apr 28 1929 — J. J. Demming, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (month, day and year) April 27 1929

17. I HEREBY CERTIFY, That I attended deceased from Mar 10, 1929, to April 26, 1929, that I last saw her alive on Apr 26, 1929, and that death occurred, on the date stated above, at 5:00 P.m.

The CAUSE OF DEATH* was as follows:

Oral & Intestinal Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (SECONDARY) Influenza

(duration) yrs. 1/2 mos. ds.

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

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) T. A. Blackmore, M. D

4-28, 1929 (Address) Windsor, Mo.

*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
Windsor Mo.	April 29 9
20. UNDERTAKER C. A. Roof	ADDRESS Windsor Mo

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.

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REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

SUPPLEMENTARY

1. PLACE OF DEATH

County Henry — Registration District No. 14 — File No.

Township — Primary Registration District No. 4211 — Registered No. 14

City Windsor (No. ..., ... St. ... Ward)

2. FULL NAME Drusilla Ann 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 ... yrs. ... mos. ... ds. How long in U.S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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)

PARENTS
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 ..., 19... — Deming — REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 27 1929

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Oral & Intestinal Hemorrhage
[illegible]
(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (SECONDARY) Influenza
(duration) ... yrs. ... mos. ... ds.

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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 ... 19

20. UNDERTAKER — ADDRESS

S-14465