

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.

AUG 13 1929

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

Do not use this space.

27341

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1. PLACE OF DEATH

County *Greene*
Towship
City *Greenfield Mo.*

Registration District No. *237*
Primary Registration District No. *4144*

File No.
Registered No.
St. Ward)

2. FULL NAME

Jessie A. Arbogast
(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.

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 *Jas. T. Arbogast*
6. DATE OF BIRTH (MONTH, DAY AND YEAR) *May 7, 1847*
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
82 2 29
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *House wife*
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Indianapolis*
(STATE OR COUNTRY) *Indiana*

10. NAME OF FATHER *Eliza Dodd*
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Virginia*
12. MAIDEN NAME OF MOTHER *Unknown*
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

14. INFORMANT *Jesse Arbogast*
(Address) *Greenfield, Mo.*

15. FILED *8-13-29* *E. C. Ball*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Aug. 6, 1929*
17. I HEREBY CERTIFY That I attended deceased from *July 31, 1929* to *Aug 6, 1929*
that I last saw *her* alive on *Aug 6, 1929*, and that death occurred, on the date stated above, at *6.15 p.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Nephritis of Kidneys
131 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)
129W (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRIBUTED
IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) *G. W. Ward*, M. D.
, 19 (Address) *Greenfield, 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
Lockwood Cemetery Aug 8 1929

20. UNDERTAKER ADDRESS
G. W. Ward Greenfield, Mo.

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