

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.

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

336540
File No. _____
Registered No. 4150

1. PLACE OF DEATH
 County Jackson Registration District No. 399
 Township Ham Primary Registration District No. 1002
 City St. Joseph (No. St. Joseph Hosp) St. _____ Ward _____

2. FULL NAME Mary Lee Arnold
 (a) Residence No. 5574 Holman 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 30 1929

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, 12 hrs. or min. _____

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Baby
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Kansas City Mo (STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Edwin Eugene Arnold
 (STATE OR COUNTRY) California

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

12. MAIDEN NAME OF MOTHER Mary Percecia Jones
 (STATE OR COUNTRY) Browning Mo

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

14. INFORMANT Edwin Eugene Arnold DATE OF BURIAL _____
 (Address) 5574 Holman 10/1/29 19

15. FILED 10/1 29 M. M. Crowe REGISTRAR
awr

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 1 - 2¹⁵ AM - 1929

17. I HEREBY CERTIFY, That I attended deceased from 9-30/29 to 10-1-1929
 that I last saw him alive on Sept 30 12:30 PM, and that death occurred, on the date stated above, at 2/15 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Want of closure of foramen ovale in heart.
157C (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) 1. 7/15/29 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH. _____

9. DID AN OPERATION PRECEDE DEATH. _____ DATE OF _____

10. WAS THERE AN AUTOPSY. Yes

WHAT TEST CONFIRMED DIAGNOSIS. _____

(Signed) J. F. Miller M. D.
10/1 1929 (Address) 1203 Waldheim Bldg

*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 Forest Hill Cmn DATE OF BURIAL 10/1/29 19

20. UNDERTAKER M. F. Mayberry No 1 ADDRESS City Mo

