

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

Do not use this space.

38377

1. PLACE OF DEATH

County.....

Registration District No. **791**
1003

File No. **10735**

Township.....

Primary Registration District No.

Registered No.

City.....

Soligo (No. *Missouri Pacific Hospital*) St. (Ward)

2. FULL NAME

(a) Residence. No. St. **17** Ward. **Van Buren, Ark.**

(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

m

4. COLOR OR RACE

w

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

married

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

Theremia Remes

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

May 21-1866

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

63

5

10

8. OCCUPATION OF DECEASED

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

Brickman

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

Mo Pac RR Co.

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Holland

10. NAME OF FATHER

Arnold Remes

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Holland

12. MAIDEN NAME OF MOTHER

not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

" "

14. INFORMANT

(Address)

*Mr. Emil Remes
Van Buren, Ark.*

15.

FILED NOV - 1 1929

Emil Remes
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Nov 1** 19**29**

17. I HEREBY CERTIFY, That I attended deceased from **Oct 20**, 19**29**, to **Nov 1**, 19**29** that I last saw him alive on **Nov 1**, 19**29**, and that death occurred, on the date stated above, at **1:20** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*Chronic Myocarditis
Acute Cardiac failure*

CONTRIBUTORY (SECONDARY)

*Acute cholelithiasis
(See Record) Several*

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

1. DID AN OPERATION PRECEDE DEATH? **yes** DATE OF **Nov 1 1929**

2. WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) *L. Harrison* M. D.

Nov 1, 1929 (Address) *Mr. Pac Hospital*

*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

Van Buren, Ark **Nov 1 1929**

20. UNDERTAKER

ADDRESS

Pete Brown 3029 Lafayette St

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.

9
13
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