

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

Do not use this space.

12498

1. PLACE OF DEATH

County Jackson Registration District No. 398
 Township Blair Primary Registration District No. 3019
 City Independence (No. Sanitarium) St. _____ Ward _____

File No. _____
 Registered No. 135

2. FULL NAME

James Hickman Arterburn
 (a) Residence. No. Fredrick Street 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 male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED x
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 23-1930

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>x</u>	<u>x</u>	<u>x</u>	

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) Independence
 (STATE OR COUNTRY)

10. NAME OF FATHER James H. Arterburn
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Mo
 12. MAIDEN NAME OF MOTHER Edna Baron
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Kansas City
 (STATE OR COUNTRY) Mo

14. INFORMANT James H. Arterburn
 (Address) Fredrick St.

15. FILED 4-24-30 J. L. Cook
 REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 23, 1930

17. I HEREBY CERTIFY, That I attended deceased from 4:25, 1930, to 7:23, 1930 that I last saw him alive on 4/23, 1930, and that death occurred, on the date stated above, at 9:30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Failure of Respiratory center
Never initiated - Heart action
persisted 1 hr
16.05 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Long labor Forceps
Delivery (duration) yrs. mos. ds.

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

9 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS clinical
 (Signed) W. E. [Signature] M. D.

4-23-30 (Address) Independence, 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 Mound Grove DATE OF BURIAL 4-23-1930

20. UNDERTAKER J. L. Latta, Independence ADDRESS _____

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.

MAY 26 1930

