

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

Do not use this space.

23828

1. PLACE OF DEATH

County Carter
Township Madelia
City Madelia (No. _____)

Registration District No. 668
Primary Registration District No. 5889

File No. _____
Registered No. 190
St. _____ Ward _____

2. FULL NAME

B Charles L. Arvey

(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 3 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>✓</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Jan 7 = 1856</u>		
7. AGE YEARS <u>74</u>	MONTHS <u>6</u>	DAYS <u>15</u>
IF LESS than 1 day, _____ hrs. or _____ min.		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Labor
(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)
Ill

10. NAME OF FATHER Gilbert Arvey

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)
no

12. MAIDEN NAME OF MOTHER Nancy Barrett

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)
no

14. INFORMANT (Address)
Mrs S. Metts La Monte Mo

15. FILED 7-25-30 J. L. Love REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 22 1930

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocardial Regurgitation
920
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY Valvular (SECONDARY)
(duration) _____ yrs. 3 mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
no

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) [Signature], M. D.
, 19____ (Address) Madelia 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
La Monte, Mo DATE OF BURIAL July 23 1930

20. UNDERTAKER
B. F. O'Connell ADDRESS La Monte Mo

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 VERY important.

AUG 26 1930

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