

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

Do not use this space.

39779

JAN 20 1930

PLACE OF DEATH

County Gasconade Registration District No. 409
 Townships Gasconade Primary Registration District No. 4042
 City Gasconade (No. 12 mi. S. of Gasconade) Ward

File No. 32
 Registered No. _____

2. FULL NAME

George W. Arne

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 18-1856

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	73	11	15	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work brush
 (b) General nature of industry, business, or establishment in which employed (or employer) Gardner
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) N. Y.

PARENTS

10. NAME OF FATHER Hamilton W. Arne

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) No record

12. MAIDEN NAME OF MOTHER Nancy Fitch

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) No record

14. INFORMANT George W. Arne Jr. (Address) Gasconade Mo.

15. FILED 12/7 1930 at Gasconade REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 3-1930

17. I HEREBY CERTIFY, That I attended deceased from Dec 1-30 to Dec 3 1930 that I last saw him alive on Dec 1 1930 and that death occurred, on the date stated above, at 4-30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Nephritis
181
 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 12/1
 (duration) yrs. mos. ds.

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

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

WHAT TEST CONFIRMED DIAGNOSIS _____ (Signed) J. J. O'Brien M. D.

12-4-1930 (Address) Gasconade 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 Forest Park Co DATE OF BURIAL 12-5-1930

20. UNDERTAKER Wendell H. ... ADDRESS _____

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

