

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.

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

Do not use this space.

26031

1. PLACE OF DEATH

County St. Charles
Township Payson
City St. Peters (No. _____)

Registration District No. 760
Primary Registration District No. 6001

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

2. FULL NAME

(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 Mrs Anna Arnold

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 15 1864

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
66 10 12

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer none

9. BIRTHPLACE (CITY OR TOWN) St. Peters
(STATE OR COUNTRY) Mo.

PARENTS

10. NAME OF FATHER Jacob Arnold

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

12. MAIDEN NAME OF MOTHER Frazer Johnson

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

14. INFORMANT Anna Sanders
(Address) St. Peters Mo

15. FILED 7-27 1931 J. M. Jenkins M. D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-26 1931

17. I HEREBY CERTIFY, That I attended deceased from July 20 1931 to July 26 1931, that I last saw him alive on July 26 1931, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Michael Insufficiency
Chronic interstitial Nephritis
131
92A (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) 131 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

19. DID AN OPERATION PRECEDE DEATH: _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS: _____

(Signed) D. D. Johnson, M. D.
7/28 1931 (Address) 200 E. Main St. St. Charles 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 St. Saints Cem DATE OF BURIAL July 30 1931

20. UNDERTAKER Henry Mahan ADDRESS St. Peters Mo

2274. 1974

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