

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

Do not use this space.

MAY 25 1934

1. PLACE OF DEATH

County Cass Registration District No. 156 File No. 12168
 Township Grand River Primary Registration District No. 4090 Registered No. 26
 City Harrisonville St. _____ Ward _____

2. FULL NAME Laura H. Arnold

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widow

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 2, 1934

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

22. 2 **HEREBY CERTIFY**, That I attended deceased from Mar 21 1934 to Apr 2 1934

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 10-1856

I last saw him alive on Apr 21 1934 Death is said to have occurred on the date stated above, at 4:15 P. m.

7. AGE YEARS 78 MONTHS 2 DAYS 22 If LESS than 1 day, _____ hrs. or _____ min.

The principal cause of death and related causes of importance were as follows:

(Mitral Insufficiency)
Cerebral Hemorrhage (Date of onset)

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Home maker

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

Other contributory causes of importance: None

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

13. NAME William Hoeker

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

15. MAIDEN NAME Sarah Morrison

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ky.

17. INFORMANT Laura Arnold (ADDRESS) Harrisonville Mo.

18. BURIAL, CREMATION? OR REMOVAL PLACE Orent Cemetery DATE 4/4 1934

19. UNDERTAKER Wm. S. Long (ADDRESS) Harrisonville Mo.

20. FILED 43 1934 D. S. Long Registrar.

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____ If so, specify _____

(Signed) David S. Long, M. D.

(Address) _____

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

10v 2/2/34

