

1938

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

41847
Do not use this space.

Registered No. 4913

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399

(b) Township Kan Primary Registration District No. 1002

(c) City Cameron City (d) Street No. 72 C Gen Hosp Registered No. 4913 St. _____

(e) Length of residence in city or town where death occurred yrs. mos. ds. 0 How long in U.S., if of foreign birth? yrs. mos. ds. _____

2. PRINT FULL NAME Arthur R. Carnes

(a) Residence, No. 3512 E. 126 St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 29, 1885

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>52</u>	<u>11</u>	<u>17</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Laborer

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

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

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

FATHER

13. NAME Henry Carnes

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

MOTHER

15. MAIDEN NAME Alice Cornelius

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

17. INFORMANT (ADDRESS) Deana Clark
72 C Gen Hosp PCM

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Moriah DATE Dec 18, 38

19. FUNERAL DIRECTOR (NAME) (ADDRESS) John B. Johnston
City

20. FILED Dec 19, 38 M. M. Brown
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-16 1938

22. I HEREBY CERTIFY, That I attended deceased from 12-14, 1938 to 12-16, 1938

I last saw him alive on 12-16, 1938. Death is said to have occurred on the date stated above, at 5:15 a.m.

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

Bilateral Lobar
Pneumonia
100

Date of onset _____

Other contributory causes of importance: _____

Name of operation _____ Date of _____

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

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) A. De Manna M.D., M. D.

(Address) Super Gen Hosp PCM

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.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

....., or by

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.