

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

33723

Do not use this space.

1. PLACE OF DEATH

(a) County Sullivan Registration District No. 855  
(b) Township Polk Primary Registration District No. 6120  
(c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. \_\_\_\_\_ St. ☐ (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 12, 1881

7. AGE YEARS 58 MONTHS 0 DAYS 7 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer  
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) Russell County Virginia

FATHER 13. NAME Noah Arttrip

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

MOTHER 15. MAIDEN NAME Melissa Fletcher

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

17. INFORMANT (ADDRESS) Mrs. May Arttrip, Milan, Mo.

18. BURIAL, CREMATION, OR REMOVAL Cabwood Cemetery, Sept 24, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) C. A. Schaefer, Milan, Mo.

20. FILED Oct. 1, 1939 Cleo Hagin Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 19, 1939

22. I HEREBY CERTIFY, That I attended deceased from Aug. 31st, 1939, to Sept 19th, 1939.

I last saw him alive on Sept. 18th, 1939. Death is said to have occurred on the date stated above, at 10:20 a.m.

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

Carcinoma of Liver  
may have been  
complicated by  
malignancy

Date of onset

Other contributory causes of importance:

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? X-ray Was there an autopsy? no

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? no

If so, specify \_\_\_\_\_

(Signed) L. Grace Simmons, M.D.

(Address) Milan, Mo.

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, \_\_\_\_\_

*Frank D. Schwene*

or by \_\_\_\_\_

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

Signed \_\_\_\_\_

*Frank D. Schwene*

Licensed Embalmer No. \_\_\_\_\_

*2016*

P. O. Address \_\_\_\_\_

*Milan*

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.