

15 1940

State File No. _____

Registration District No. 50

Primary Registration District No. 3064

Registrar's No. 42

1. PLACE OF DEATH:

(a) County Bates
(b) City or town Butler
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Butler Memorial 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____
years, months or days) 5 1/2

3. (a) PRINT FULL NAME William Masby Arnold

3. (b) If veteran, _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mrs Anne Arnold 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 25 1858
(Month) (Day) (Year)

8. AGE: 82 Years Months Days If less than one day
hr. min.

9. Birthplace Lafayette Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Real-Estate

11. Industry or business _____

12. Name John Early Arnold

13. Birthplace Campbell Co. Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Allen

15. Birthplace Merriis Town TENN.
(City, town, or county) (State or foreign country)

16. (a) Informant M. F. Arnold

(b) Address Butler, Mo.

17. (a) Burial (b) Date thereof April 26 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Hill, Butler

18. (a) Signature of funeral director Butler, Mo.

(b) Address Butler, Mo.

19. (a) April 26 1940 (b) Nina L. Cline
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Bates
(c) City or town Butler
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

20. DATE OF DEATH: Month April day 25 year 1940 hour 4:30 minute 9 M.
MEDICAL CERTIFICATION

21. I hereby certify that I attended the deceased from 10th
1940 to May 25 1940
that I last saw him alive on Apr 24th 1940
and that death occurred on the date and hour stated above.

Immediate cause of death General toxemia
due to rupture of
the leg from papule
due to thrombosis and
general arteriosclerosis
Due to _____
Due to _____

Other conditions prostatic adenoma
(Include pregnancy within 3 months of death)
Mar 20th 1940

Major findings:
Of operations _____
Of autopsy _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 52

(Specify type of place)
While at work _____ (e) Means of injury _____

23. Signature L. A. La. Kure (M. D. or other) med
Address Butler, Mo. Date signed 4/24/40

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RECEIVED
District Health Officer No. 7,
District File Number 5-40-849
Date Filed 5-13-42

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

B. Denton Lisle

Licensed Embalmer No.

4123

P. O. Address

Butler, Mo.

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **14217**

Registration District No. **30**

Primary Registration District No. **3004**

Registrar's No.

1. PLACE OF DEATH:

(a) County **Bates**
(b) City or town **Butler**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution
In this community (Specify whether years, months or days)

3. (a) PRINT FULL NAME

William Mosby Arnold

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex **M**

5. Color or race **W**

6. (a) Single, widowed, married, divorced **M**

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased

(Month) (Day) (Year)

8. AGE:

Years **82**
Months
Days

If less than one day h min

9. Birthplace

(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

(City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace

(City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a)

(b) Date thereof

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a)

(b)

(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town

(If outside city or town limits write "RURAL")

(d) Street No.

(If rural, give location)

(e) If foreign born, how long in U. S. A.?

years

MEDICAL CERTIFICATION

20. DATE OF DEATH

Month **Apr** day **25**

year **1940** hour minute M.

21. I hereby certify that I attended the deceased from

19 to 19

that I last saw h. alive on

and that death occurred on the date and hour stated above

Immediate cause of death

General Toxemia

Due to **leukemia** of **prostatic** origin and **general arterio sclerosis**

Other conditions

(Include pregnancy within 3 months of death)

Major findings

Of operation **Prostatectomy**

Of autopsy **(Hypertrophy)**

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work

(Specify type of place)

(e) Means of injury

23. Signature

(M. D. or other)

Address

Date signed

SUPPLEMENT

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

