

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

15393
Do not use this space.

1. PLACE OF DEATH

(a) County Livingston 1 Registration District No. 508
 (b) Township _____ Primary Registration District No. 3026 Registered No. 45
 (c) City Chillicothe 0 (d) Street No. Chillicothe Hospital 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. 6 0 0 How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Katherine Evelyn Arabast
 (a) Residence, No. Barado St. Missouri
 (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 Female 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 Jaylor Arabast

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

7. AGE YEARS 51 MONTHS 2 DAYS 8 If LESS than 1 day, hrs. or min.

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

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) April 1940 11. Total time (years) spent in this occupation 33

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Chula, Mo

FATHER 13. NAME Stephen Nelson

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

MOTHER 15. MAIDEN NAME Sadie Roberts

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

17. INFORMANT Jaylor Arabast
(ADDRESS) Barado, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Barado DATE April 2, 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. P. Robertson
Barado, Mo.

20. FILED 4-9 1940 H. M. Lewis, M.D.
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 2, 1940

22. I HEREBY CERTIFY, That I attended deceased from March 27, 1940 to April 2, 1940
 I last saw her alive on April 2, 1940 Death is said to have occurred on the date stated above, at 7:00 p.m.

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

Basal Destruction
12/2/39
 Date of onset

Other contributory causes of importance:
Post-operative basal
loop in omentum
opening suspension

Name of operation basal loop Date of operation 12-3-40

What test confirmed diagnosis? pathology 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 no fire
 Nature of injury basal

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____ (Signed) R. J. Brennan M. D.

(Address) Chillicothe, Mo

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

I-X14023

RECEIVED

District Health Officer No. 11,
District File Number 540-700
Date Filed **MAY 9 1940**

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 *E. J. Robertson*

Licensed Embalmer No. *2465*

P. O. Address *Fairfax, Md*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 13393
Registrar's No. 45-

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
Registration District No. 308

Primary Registration District No. 3026

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

1. PLACE OF BIRTH:
(a) County Linn
(b) City or town Chillicothe
(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)

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.

3. (a) PRINT FULL NAME Walterine Evelyn Grabert
(b) If veteran, name war _____ (c) Social Security No. _____

20. DATE OF DEATH. Month apr day 2 year 1940 hour _____ minute _____ M.

4. Sex 7 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

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____ and that death occurred on the date and hour stated above.

7. Birth date of deceased. January 24 1889
(Month) (Day) (Year)
8. AGE: Years 51 Months 2 Days 8 If less than one day _____ min.

Immediate cause of death _____
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)
10. Usual occupation _____

Major findings: Of operations _____
Of autopsy _____

11. Industry or business _____
12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____ (State or foreign country)
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

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? _____
(Specify type of place) _____ (e) Means of injury _____

16. (a) Informant _____ (b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(c) Place: burial or cremation _____
18. (a) Signature of funeral director _____
(b) Address _____
19. (a) 4-9-40 (b) H.W. Moore M.D.
(Date received from registrar) (Registrar's signature)

23. Signature R.D. Brennan (M. D. or other) _____
Address Chillicothe Date _____

SUPPLEMENTARY MEDICAL CERTIFICATION

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

