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

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 19008

FILED JUN 22 1940

Registration District No.

Primary Registration District No. 5757

Registrar's No.

1. PLACE OF DEATH:
(a) County Miller
(b) City or town Dixon, Mo. R3
(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 ——— (Specify whether years, months or days)
In this community ———

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Miller
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Dixon, Mo. R3
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ——— years.

3. (a) PRINT FULL NAME Nancy Arendall 653

3. (b) If veteran, name war ———

3. (c) Social Security No. None

4. Sex Fem

5. Color or race White

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife James Arendall

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

7. Birth date of deceased Apr. 24 1853 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
86	9	25	hr. min.

9. Birthplace Maries County, Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Housekeeper

11. Industry or business

FATHER
12. Name John Crisman
13. Birthplace Vienna, Mo (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Melissa Bradlaw
15. Birthplace Osage, Mo (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Fred Whitaker
(b) Address Dixon, Mo. R.3

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 22, 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Baylean, Dixon, Mo. R3

18. (a) Signature of funeral director C. L. Casey
(b) Address Iberia, Mo

19. (a) May 28 '40 (Date received by local registrar) (b) Mrs. W. A. Van Gorny (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 20 year 1940 hour 3 minute 30 P M.

21. I hereby certify that I attended the deceased from 2-18-40, 19..., to 2-20, 1940, that I last saw her alive on 2-18, 1940, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Hypostatic Pneumonia & Senility	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	PHYSICIAN
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature G. W. Crisman (M. D. or other)
Address Iberia, Mo. Date signed

(Licensed Embalmer's Statement on Reverse Side)

50M-5-17-39 Rev. 5-17-39 I X19511

RECEIVED
Miller County Health Dept
County File Number 40-67
Date Filed 6-10-40

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 Larsen Adams, Registered Apprentice No. 211, working under my personal supervision.

Signed E. L. Casey

Licensed Embalmer No. 2694

P. O. Address Iberia, 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.

U. S. No. 2B
DM—2-21-40
I X22659

ROWENA MOORE

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 19008

Registration District No. 562

Primary Registration District No. 5-457

Registrar's No.

1. PLACE OF DEATH:

(a) County Miller

(b) City or town Richwood

(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 (Specify whether years, months or days)

In this community

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 Nancy Arendall

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced wid

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 86 | Months 9 | Days 25 | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 20 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 , 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death (Hypostatic Pneumonia	
Due to (Bronchopneumonia)	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations

Of autopsy

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature R W Duncan (M. D. or other)

Address Licensed Date signed

SUPPLEMENTARY

1078

S-19008