

Registration District No. 527

Primary Registration District No. 5703

Registrar's No.

1. PLACE OF DEATH:

(a) County Macon
(b) City or town BEVIER
(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

In this community years, months or days)

3. (a) PRINT FULL NAME Edward Arrington

3. (b) If veteran, name war. 3. (c) Social Security No. 489-14-7846

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

6. (b) Name of husband or wife. 6. (c) Age of husband or wife if

7. Birth date of deceased 12-25-1870 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 5 29 hr. min.

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

10. Usual occupation A.P.A. WORKER

11. Industry or business

MOTHER FATHER { 12. Name UNKNOWN

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

14. Maiden name UNKNOWN

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

16. (a) Informant's own signature LENA CAMPBELL

(b) Address BEVIER, MO

17. (a) BURIAL (b) Date thereof 6-26-40 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bevier Mo

18. (a) Signature of funeral director W. Edwards

(b) Address Bevier Mo

19. (a) 7-9-1940 (b) Edw. Simpson (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Macon

(c) City or town Bevier (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 JUNE day 24 year 1940 hour 12 minute 15 P.M.

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

Immediate cause of death Peritonitis (acute) Duration 7 days

Due to Hernia (chronic) 30 days

Due to acute nephritis 7 days

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 122 W

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?

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

23. Signature Dr. E. L. Edwards (If other than physician)

Address Bevier, Mo Date signed 7/3/40

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.....

....., 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.