

FILED SEP 24 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **29186**

Registration District No. **605**

Primary Registration District No. **4359 5804**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **New Madrid**
(b) City or town **Parma**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **2**
(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) **Twenty one years**
In this community **Twenty one years**

3. (a) PRINT FULL NAME **Elizabeth "Bessie" Arnesman**

3. (b) If veteran, name war **none** 3. (c) Social Security No. **none**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband **none** 6. (c) Age of husband or wife if alive **years**

7. Birth date of deceased **Oct 5 1853**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
86 10 7 hr. min.

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

10. Usual occupation **House keeping**

11. Industry or business **none**

MOTHER FATHER { 12. Name **Andrew Barker** 9
13. Birthplace **Wisconsin** (City, town, or county) (State or foreign country)
14. Maiden name **Rachel Wertz** 9
15. Birthplace **Wisconsin** (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Paul Shinsley**
(b) Address **Parma Mo**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Aug 13 - 40**
(Month) (Day) (Year)
(c) Place: burial or cremation **Parma Cemetery**

18. (a) Signature of funeral director **T. C. Knight**
(b) Address **Parma Mo**

19. (a) **Aug 5/40** (b) **Dr. George J. Foster**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **New Madrid**
(c) City or town **Parma** (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 **August** day **11th**
year **1940** hour **2:50 PM** minute _____ M.
21. I hereby certify that I attended the deceased from **Aug 5, 1940**
_____ 19____, to **Aug 11, 1940**
that I last saw her alive on **Aug 11, 3 P.M.** 19____
and that death occurred on the date and hour stated above.
Immediate cause of death **Acute Colitis** **85-40**

Due to **Chronic Nephritis**
Due to **120 lb**

Other conditions (Include pregnancy within 3 months of death)
Major findings: **None**
Of operations **None**
Of autopsy **None**

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? **534**

(Specify type of place)
While at work? **Yes** (g) Means of injury _____
23. Signature **Edward Ford** (M. D. or other) **1**
Address **Parma, Mo** Date signed **8-11-40**

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No.

District File Number 940-1

Date Filed 9/11/4

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, [Signature]

[Signature], Registered Apprentice No. _____,
working under my personal supervision.

Signed

Thomas C. Knight

Licensed Embalmer No. 2109

P. O. Address

Parma 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.