

DEPARTMENT OF COMMERCE

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 59

Primary Registration District No. 4092

Registrar's No. 51

1. PLACE OF DEATH

(a) County Cass  
(b) City or town Archie Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution 1

(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution all his life (Specify whether years, months or days)

3. (a) PRINT FULL NAME Charles Wesley Arnold

8. (b) If veteran, no name war \_\_\_\_\_ 3. (c) Social Security No. no

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Florence Arnold 6. (c) Age of husband or wife if alive 70 years  
7. Birth date of deceased 8-22-1873 (Month) (Day) (Year)

8. AGE: Years 69 Months 3 Days 27 If less than one day hr. min.

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

10. Usual occupation farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Jacob Arnold  
13. Birthplace Pa. (City, town, or county) (State or foreign country)  
14. Maiden name Edwina Crawford  
15. Birthplace Pa. (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Florence Arnold

(b) Address Archie Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-21-1943 (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director William B. ...

(b) Address Archie Mo

19. (a) March 11, 1943 (Date received local registrar) (b) Margaret ... (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Cass  
(c) City or town Archie (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. 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 19 year 1943 hour 7 minute 15 A.M.

21. I hereby certify that I attended the deceased from Jan. 12 1943 to Jan. 18 1943

that I last saw him alive on Jan. 18 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia, lobar.

Due to Cardio-vascular, renal trouble.

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 108

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 E. E. Robinson (M. D. or other)

Address Archie, Mo. Date signed 1-19-43

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

**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.....

*Floyd W. Harrison*

Licensed Embalmer No. *3940*

P. O. Address.....

*Harrisville 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.**