

No. 2
5-42
17-36
x
FILED JUN 7 1948

16803
State File No. _____
Registrar's No. 2312

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Registration District No. 149 Primary Registration District No. 1002

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

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1731 Indiana Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community Approximately 35 yrs. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 1731 Indiana Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Dewitt T. Arnold
3. (b) If veteran, name war No 3. (c) Social Security No. 496-09-9898

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Myrtle R. Arnold 6. (c) Age of husband or wife if alive 45 years
7. Birth date of deceased Aug. 24th. 1891
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
51 8 24 _____ hr. _____ min.

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

10. Usual occupation Laborer

11. Industry or business Centropolis Transfer Co.

MOTHER FATHER { 12. Name Wayne Arnold
13. Birthplace Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Lizzie Decker
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Myrtle Arnold

(b) Address 1731 Indiana Ave. K.C. Mo.

17. (a) Burial (b) Date thereof May 21-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove, Mo.

18. (a) Signature of funeral director Rose & Henderson

(b) Address 4139 East 15th St. K.C. Mo.

19. (a) 5-20-43 (b) D. M. Browne
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 5 day 18 year 43 hour 5:00 minute P M.
21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage
Chronic hypertension
acute pulmonary edema
Due to _____
Duration _____
Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN _____
Underline the cause to which death should be charged statistically.
Major findings: _____
Of operations _____
-Of autopsy See above

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 D. M. Browne (or other) _____
Address _____ Date signed _____

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.....

John B. Kemp

Licensed Embalmer No.....

2455

P. O. Address.....

H.C. Mer

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, fact should be so stated above.