

FILED JUL 14 1943

53

Primary Registration District No. 5190

1. PLACE OF DEATH:

(a) County Carroll (Rural)  
(b) City or town Carrollton (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 17 1/2 mos. (Specify whether years, months or days)  
In this community years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Carroll  
(c) City or town Carrollton (If outside city or town limits, write "RURAL")  
(d) Street No. .... (If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 6  
year 1943 hour 11 minute 45 A.M.  
21. I hereby certify that I attended the deceased from May 31st 1943 to June 6th 1943  
that I last saw her alive on June 6 1943  
and that death occurred on the date and hour stated above.

Duration

Immediate cause of death Broncho pneumonia 4 days

Due to Mongolian (Feeble minded)

Due to Brain Tumor

Other conditions (Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:  
Of operations .....  
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 0

23. Signature W.S. Steward (M. D. or other)  
Address Carrollton Mo. Date signed 6/14/43

3. (a) PRINT FULL NAME Gloria Jeanne Arbenz

3. (b) If veteran, name war ..... 3. (c) Social Security No. ....

4. Sex Fe 5. Color or race W 6. (a) Single, widowed, married, divorced, Single

6. (b) Name of husband or wife ..... 6. (c) Age of husband or wife if alive ..... years (Day) (Year)

7. Birth date of deceased Mar 2 1925 (Month) (Day) (Year)

8. AGE: Years 18 Months 3 Days 4 If less than one day hr. min.

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

10. Usual occupation Child

11. Industry or business

12. Name Geo. H. Arbenz

13. Birthplace Wheeling W. Va. (City, town, or county) (State or foreign country)

14. Maiden name Yellie Doyle

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

16. (a) Informant Mrs. Henry E. Allan

(b) Address 2732 Charlotte, K. C. Mo.

17. (a) Burial (b) Date thereof 6-8-43 (Month) (Day) (Year)

(c) Place: burial or cremation Elmwood Cem. K. C. Mo.

18. (a) Signature of funeral director Mrs. C. Foster

(b) Address Kansas City Mo.

19. (a) 6-8-1943 (Date received local registrar) (b) Mar. Frank R. ... (Registrar's signature)

11 6 3

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

MOTHER FATHER

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed 7-13-43

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:

*Benjil C. Browning*

Licensed Embalmer No. 2724

P. O. Address 918 Brooklyn K.C.

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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

JUL 24 1943  
State File No. \_\_\_\_\_  
Registrar's No. 69

Registration District No. 55 Primary Registration District No. 5190

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

1. PLACE OF DEATH:

(a) County Carroll

(b) City or town Carrollton Tenn  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: No. State School no 2.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Several years  
(Specify whether years, months or days)

In this community \_\_\_\_\_  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Glorie Jeanne Ardery

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

4. Sex A 5. Color or race W 6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased March 2 1925  
(Month) (Day) (Year)

8. AGE: Years 18 Months 3 Days \_\_\_\_\_ If less than one day min. \_\_\_\_\_

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

10. Usual occupation \_\_\_\_\_

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

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

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

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) Mrs James Rafferty  
(Date received local registrar) (Registrar's signature)

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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1943  
year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death broncho pneumonia  
meningitis  
cellulitis (mended)

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

Due to Possible

Other conditions Brain Tumor  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_ 107

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 William S. Alwood (M. D. or other) \_\_\_\_\_  
Address Carrollton Mo Date signed 7/19/43

SUPPLEMENTARY

5-21031