No. 2
5-42
5-17-39
X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 17 1943

Registration District No. 37-4

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 22719

Primary Registration District No. 6273

Registrar's No.

**1. PLACE OF DEATH:**

(a) County Worth

(b) City or town Rural GRANT CITY Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: [illegible]
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether)
In this community 42 years
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo. (b) County Worth

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. GRANT CITY Mo.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Josephine Virginia Arnold

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex

5. Color or race W

6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife H. H. Arnold

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Sept (Month) 25 (Day) 1854 (Year)

8. AGE: Years 88 Months 6 Days 28 If less than one day hr. min.

9. Birthplace Grafton (City, town, or county) West Virginia (State or foreign country)

10. Usual occupation housewife

11. Industry or business

FATHER
12. Name Henry Reynolds
13. Birthplace (City, town, or county) (State or foreign country) ?

MOTHER
14. Maiden name Lydia Neff
15. Birthplace (City, town, or county) (State or foreign country) ?

16. (a) Informant

(b) Address

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 4-25-1943 (Month) (Day) (Year)

(c) Place: burial or cremation Ft. Cleland

18. (a) Signature of funeral director Arch C. Dunfee

(b) Address Grant City Mo.

19. (a) May 10 1943 (Date received local registrar) (b) Arlene Sanders (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 4 day 23rd year 1943 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Cerebral Hemorrhage | |
| Due to | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |
| Major findings: Of operations | |
| 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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Dudley Dean (M. D. or other)

Address Grant City Mo. Date signed 4-25-43

1164

(Licensed Embalmer's Statement on Reverse Side)

## 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 Jack C. Dunkle

Licensed Embalmer No. 3282

P. O. Address Grant City, 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, fact should be so stated above.**

No. 2B
1—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. July

Registration District No. 374 Primary Registration District No. 6273 Registrar's No. 1

**1. PLACE OF DEATH:**

(a) County Worth

(b) City or town Rural
(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 (Specify whether years, months or days)

In this community

**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

3. (a) PRINT FULL NAME Josephine V. Arnold

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex (F)

5. Color or race W

6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive Years

7. Birth date of deceased Sept 25 1850
(Month) (Day) (Year)

8. AGE: Years 88 | Months 6 | Days | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER / FATHER

12. Name

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

MOTHER

14. Maiden name

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

16. (a) Informant Mrs Elmer Mercer

(b) Address Grant City, Mo.

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) May 10 - 1943 (Date received local registrar) (b) Arlene Scribner (Registrar's signature)

SUPPLEMENTARY

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month April day 13 year 1943 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death | |
| Due to | |
| Due to | |
| 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

23. Signature (M. D. or other)

Address Date signed

5-22710