

FILED NOV 1 1943

149

Primary Registration District No. _____

1002

Registrar's No. _____

4207

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City Mo
(c) Name of hospital or institution: St. Joseph's
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution About 5 weeks
In this community About 5 wks.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME

Georgia Olive Arnold

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married
(b) Name of husband or wife Henry Arnold 6. (c) Age of husband or wife if alive 43 years
7. Birth date of deceased May - 9 - 1906
(Month) (Day) (Year)

8. AGE: Years 37 Months 4 Days 23
If less than one day hr. min.

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

10. Usual occupation House wife

11. Industry or business _____

MOTHER FATHER { 12. Name George Edwards
13. Birthplace Canaan Mo
(City, town, or county) (State or foreign country)
14. Maiden name Anna Robinson
15. Birthplace Wellington Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Henry Arnold
(b) Address Brich Mo
17. (a) Rural (b) Date thereof 10-4-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Cemetery
18. (a) Signature of funeral director E. V. Gibson
(b) Address Brich Mo
19. (a) 10-4-43 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 2
year 43 hour 8 minute 10 M.

21. I hereby certify that I attended the deceased from Aug 30-43 1943 to Oct 1-43 1943
that I last saw him alive on Oct 1-43 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Lung abscess Duration ✓

Due to had "influenza" several weeks ago

Due to Pregnant

Other conditions (Include pregnancy within 4 months of death) _____
Major findings: Of operations Lung abscess
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: not
(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 Wm. Williams M.D. (M. D. or other)
Address 736 Maple Bldg Date signed Oct 2

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.....

C.V. Gibson....., Registered Apprentice No.
working under my personal supervision.

Signed C.V. Gibson.....

Licensed Embalmer No. 2299.....

P. O. Address Orick Me.....

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.

Registration District No. 149

Primary Registration District No. 1002

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:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. (Specify whether

In this community
years, months or days

3. (a) PRINT FULL NAME Georgi Olene 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 m

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

7. Birth date of deceased may 9
(Month) (Day) (Year)

8. AGE: Years 37 Months 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) (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) (Date received local registrar) (b) (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: Month April Day 2
year 1943 hour minute M.

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

Immediate cause of death Lung abscess Duration

Due to had influenza several weeks ago

Due to

Other conditions Pregnant 330
(Includes pregnancy within 3 months of death)

Major findings: Lung abscess PHYSICIAN

Of operations Benign
Of autopsy Body delivered spontaneously, alive - had

22. If death was due to external causes, fill in the following: Home ante-mortem

(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 Wm. Williams M.D. (M. D. or other)
Address Date signed

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

SUPPLEMENTARY

