

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

34903

Registration District No. 133

Primary Registration District No. 3022

Registrar's No. 112

1. PLACE OF DEATH

- (a) County Harrison
 (b) City or town Bethany
 (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

In this community all of life (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Sarah Ida Arnold

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex
- Female
5. Color or race
- White

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

6. (b) Name of husband or wife
- Vester Arnold Dec.
6. (c) Age of husband or wife if alive
-
- years

7. Birth date of deceased
- Sept 20 1874
-
- (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
-
- 69 0 24
- hr. min.

9. Birthplace
- Harrison County Mo. 1
-
- (City, town, or county) (State or foreign country)

10. Usual occupation
- housewife

11. Industry or business

12. Name Benjamin Jennings
 13. Birthplace Harrison County Mo. 1
 (City, town, or county) (State or foreign country)
 14. Maiden name Mary Ann Hoke
 15. Birthplace Kentucky
 (City, town, or county) (State or foreign country)

16. (a) Informant
- Will Jennings

- (b) Address
- Bethany Mo.

17. (a)
- Burial
- (b) Date thereof
- Oct 15 1943
-
- (Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation
- Minion Cemetery

18. (a) Signature of funeral director
- Joe E. Wheeler

- (b) Address
- Bethany Mo.

19. (a)
- Oct 15 1943
- (b)
- Zola M. Burris
-
- (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo (b) County Harrison 41
 (c) City or town Bethany
 (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
- Oct
- day
- 14
- PM
-
- year
- 1943
- hour
- 12
- minute
- night
- M.

21. I hereby certify that I attended the deceased from
- Oct 11 1943
-
- to
- Oct 13 1943

that I last saw her alive on Oct 13 1943
and that death occurred on the date and hour stated above.Immediate cause of death Cancer of Right Breast

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 50

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 223. Signature E. F. Harding M.D. or other _____Address Bethany Mo. Date signed _____

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

