

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 10952

FILED APR 5 1944

Registration District No. 521944Primary Registration District No. 5464Registrar's No. 2

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Willard Mo. R1. Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Rural (Murray Township) Greene Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution none
(Specify whether
In this community life,
years, months or days)

3. (a) PRINT FULL NAME Bertha Ellen Arbuckle

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 Married
6. (b) Name of husband or wife Eldrid Arbuckle 6. (c) Age of husband or wife if alive 53 years
7. Birth date of deceased July 21 1891
(Month) (Day) (Year)

8. AGE: Years 52 Months 7 Days 18 If less than one day
hr. min.

9. Birthplace Greene Co Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife11. Industry or business Housekeeping12. Name Marion Robertson

13. Birthplace Mo 0
(City, town, or county) (State or foreign country)

14. Maiden name Cornelia Carter

15. Birthplace Mo 0
(City, town, or county) (State or foreign country)

16. (a) Informant Eldrid Arbuckle(b) Address Willard Mo R1

17. (a) Burial (b) Date thereof Mar 11 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Pleasant18. (a) Signature of funeral director Gene A. Bunn(b) Address Walnut Grove Mo.

19. (a) 3-10-1944 (b) Jane Appleby
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Greene 39
(c) City or town Willard Mo R1
(If outside city or town limits, write "RURAL")
(d) Street No. Rural Murray Township
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 9
year 1944 hour 10 minute a M.

21. I hereby certify that I attended the deceased from 3-1-44 to 3-5-44
that I last saw her alive on 3-5-44
and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis ✓
Duration 5 yrs.

Due to — " —Due to — " —

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

Major findings: None
Of operations

Of autopsy None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no
(b) Date of occurrence ✓
(c) Where did injury occur? ✓
(City or town) L (County) L (State) L
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? no (Specify type of place)
(e) Means of injury ✓

23. Signature B. F. Thiele (M. D. Thiele)
Address Bois d'Arc Mo Date signed 3/9/44

(Licensed Embalmer's Statement on Reverse Side)

1242

RECEIVED

State of North Carolina

44-4-31

4-4-44

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

Gene A. Brink

Licensed Embalmer No.

2664

P. O. Address

Walnut Grove

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.

2.792

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

State File No.

Registration District No. 123Primary Registration District No. 5764Registrar's No. 2

1. PLACE OF DEATH:

- (a) County Greene
(b) City or town Rural - Murray Twp
(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 Bertha Ellen Arbuck

3. (b) If veteran,
-
- name war.

3. (c) Social Security
-
- No.

4. Sex
- F
5. Color of
- W
- race
-
6. (a) Single, widowed, married,
-
- divorced
- m

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

7. Birth date of deceased
- July 2, 1908
-
- (Month) (Day) (Year)

8. AGE: Years
- 52
- Months
- 7
- Days
- 13
- If less than one day,
-
- hr. min.

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

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name

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

16. (a) Informant

- (b) Address

17. (a) (b) Date thereof
- July 2, 1944
-
- (Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation

18. (a) Signature of funeral director

- (b) Address

19. (a) (b)
- B. Thider
-
- (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: Month
- March
- day
- 13
-
- year
- 1944
- hour
- 1
- minute
- 15
- M.

21. I hereby certify that I attended the deceased from
- 1939
- to
- 1944
- ;
-
- that I last saw him
- alive
- on
- July 2, 1944
- ;
-
- and that death occurred on the date and hour stated above.
-
- Immediate cause of death
- Suberculosis
-
- (Pulmonary)
- 5 yrs
-
- Duration

- Due to
- 13th

- 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 sta-
tistically.

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 a week (Specify type of place) (c) Means of injury

23. Signature
- B. Thider
- (M.D. or other)
-
- Address Date signed

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

FILED

10952