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FILED JAN 5 1945

Registration District No. **28**

Primary Registration District No. **4134**

Registrar's No. **115**

1. PLACE OF DEATH:

(a) County **CLAY**
(b) City or town **SMITHVILLE**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution **SMITHVILLE COMMUNITY HOSPITAL**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 DAY** (Specify whether
in this community **LIFETIME** years, months or days)

2. USUAL RESIDENCE OF DECEASED:

MO. CLAY 24
(a) State (b) County
(c) City or town **SMITHVILLE, MO. R.F.D. 9**
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **MINNIE CATHERINE ARTHUR**

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 **DAVID T. ARTHUR** 6. (c) Age of husband or wife if alive **80** years

7. Birth date of deceased **JAN. 28, 1871**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
73 9 30 hr. min.

9. Birthplace **CLINTON COUNTY MO**
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSEWIFE**

11. Industry or business **FARM**

12. Name **GEORGE MILLER**

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

14. Maiden name **LYDIA CATHERINE MOONEY**

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

16. (a) Informant **DAVID T. ARTHUR**

(b) Address **SMITHVILLE, MO. R.F.D.**

17. (a) **BURIAL** (b) Date thereof **11/29/44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **PARADISE CEM. CLAY CO. MO.**

18. (a) Signature of funeral director **McConas Funeral Home Smithville, Mo.**

(b) Address **11ec 5-1944** (c) **Paul W. Henry** (Registrar's signature)
(Date received local registrar) (City, town, or county)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **NOV.** day **27**
year **1944** hour **9:45** minute **P.** M.

21. I hereby certify that I attended the deceased from **NOV. 26**
1944 to **NOV. 27** 1944
that I last saw **her** alive on **NOV. 27** 1944
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Due to **Ch Myocardia**
hypertension
uremia

Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Duration

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) Means of injury **0**

23. Signature **P. B. Hoff** (M. D. or other) **MD**
Address **Smithville, Mo** Date signed **Nov. 28 44**

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

RECEIVED
 District Officer No. 8,
 District File Number _____
 Date Filed 1-4-43

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 S. A. McComas
 Licensed Embalmer No. 2303
 P. O. Address Smithville, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan
Registrar's No. 1105

Registration District No. 72 Primary Registration District No. 4134

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

1. PLACE OF DEATH:

(a) County St. Charles
(b) City or town Smithville
(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 Minnie C. Arthur

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 _____

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

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 73 Months 9 Days 2 If less than one day _____ min. _____

9. Birthplace _____ (City, town, or county) _____ (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)

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 Jan 1947 year 19 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 1947 _____ 1947 _____

that I last saw him/her alive on _____ 1947 _____ and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Ch. myocardia

Due to hypertension

Due to ch. nephritis

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

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 _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

40921