

FILED JAN 12 1945

Registration District No. **84**

Primary Registration District No. **4147**

Registrar's No. **49**

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

1. PLACE OF DEATH:

(a) County **Cooper**
(b) City or town **Burcator**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. **4 hrs!**
(Specify whether years, months or days) **4 hrs.**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Cooper**
(c) City or town **Burcator**
(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

Unnamed Arnold

3. (b) If veteran, name war

3. (c) Social Security No. **---**

4. Sex **M** 5. Color or race **W.** 6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive **45** years
7. Birth date of deceased: **12-21-44**
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day **4** hr. _____ min.

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

MOTHER FATHER

10. Usual occupation _____
11. Industry or business _____
12. Name **Johan Walter Arnold**
13. Birthplace **Osage Co Mo**
(City, town, or county) (State or foreign country)
14. Maiden name **Paula Frances Williams**
15. Birthplace **Osage Co Mo**
(City, town, or county) (State or foreign country)
16. (a) Informant **John Walter Arnold**
(b) Address **Burcator**
17. (a) **burial** (b) Date thereof **12-22-44**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **By Pastor**

18. (a) Signature of funeral director **Wm**
(b) Address **Burcator Mo**
19. (a) **Dec 30 1944** (b) **Mrs Ester Robins**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **12-22** day _____ year **44** hour **2** minute **15 AM**
21. I hereby certify that I attended the deceased from **12-21** 19____ to **12-22-44** 19____; that I last saw him alive on **12-21-44** 19____; and that death occurred on the date and hour stated above.

Immediate cause of death **Patent foramen ovale**
Due to _____
Due to **157e**
Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy **none**

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) (e) Means of injury **---**
23. Signature **H. A. Hume** (M. D. or other) _____
Address **Kepton Mo** Date signed **12-22-44**

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 1-10-48

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.....

not embalmed

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

L. G. Parker

Licensed Embalmer No. 29-47

P. O. Address Burien, 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.