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7. 5-17-39  
PI X28390

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **41747**

FILED JAN 13 1945

Registration District No. **2277**

Primary Registration District No. **8-46 4371**

Registrar's No. \_\_\_\_\_

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

4  
6  
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**1. PLACE OF DEATH:**  
 (a) County Nodaway  
 (b) City or town Elmo  
(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) 1  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
 In this community 34 Years  
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County Nodaway **74**  
 (c) City or town Elmo Rural Nodaway  
(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 \_\_\_\_\_

**3. (a) PRINT FULL NAME** Fred C Argabright  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month Dec day 9  
 year 1944 hour 5 minute A M.  
 21. I hereby certify that I attended the deceased from  
July 10 1944 to Dec 6 1944  
 that last saw him alive on Dec 6  
 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race Wh  
 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Maggie Argabright 6. (c) Age of husband or wife if alive 64 years  
 7. Birth date of deceased Nov 29 1866  
(Month) (Day) (Year)

Immediate cause of death  
Myocardial Infarction  
+ hypostatic congestion  
 Due to hypertension  
Senility  
Myocardial degeneration  
 Other conditions  
(Include pregnancy within 3 months of death)

8. AGE: Years 78 Months \_\_\_\_\_ Days 10  
If less than one day  
 hr. \_\_\_\_\_ min. \_\_\_\_\_

Duration 3 days  
 PHYSICIAN  
 Underline the cause to which death should be charged statistically.  
930

9. Birthplace Nebraska  
(City, town, or county) (State or foreign country)  
 10. Usual occupation Retired Farmer  
 11. Industry or business \_\_\_\_\_

MOTHER { 12. Name John Argabright  
 13. Birthplace Illinois  
(City, town, or county) (State or foreign country)  
 14. Maiden name Hedca Clover  
 15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

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? \_\_\_\_\_

16. (a) Informant Mrs Maggie Argabright  
 (b) Address Elmo Missouri  
 17. (a) Removal (b) Date thereof Dec-11-44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Blanchard, Iowa

While at work (Specify type of place) (c) Means of injury 2  
 23. Signature Marginal End (M.D. or other) MD  
 Address Elmo Mo Date signed 12/9/44

18. (a) Signature of funeral director [Signature]  
 (b) Address Westboro, Missouri  
 19. (a) Dec 11 1944 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

1269

MAR 3 1947

**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.....

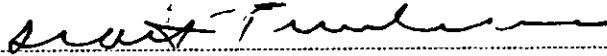
Scott Tycker

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

working under my personal supervision.

Scott Tucker

Signed.....



Licensed Embalmer No. 2359

P. O. Address.....

**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.**