

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAY 1 1945

Registration District No. 241

Primary Registration District No. 4360

Registrar's No. 23

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town Portageville
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County New Madrid
(c) City or town Portageville 12
(If outside city or town limits, write "RURAL") _____
(d) Street No. _____ (If rural, give location) _____
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME ICEY ARNOLD

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race Colored 6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____
alive _____ years

7. Birth date of deceased May 2 1901
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>43</u>	<u>11</u>	<u>5</u>	hr. _____ min. _____

9. Birthplace Belmont Mo A
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Wesley Arnold
13. Birthplace Georgia Ala 0
(City, town, or county) (State or foreign country)
14. Maiden name Annie Hickman
15. Birthplace Carinth Miss 1
(City, town, or county) (State or foreign country)

16. (a) Informant Ruthy Sherman
(b) Address R#2 Portageville, Mo

17. (a) Burial (b) Date thereof Apr 9-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Portageville Mo

18. (a) Signature of funeral director Sherman Ernest
(b) Address Stella Mo

19. (a) 4-8-45 (b) Ellen De Kise
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 7
year 1945 hour 3:00 minute _____ M.
21. I hereby certify that I attended the deceased from ✓
✓ 19 to ✓ 19 ;
that I last saw h. ✓ alive on _____ 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Hit with ax on head twice
Due to _____
Due to _____
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) Homeicide
(b) Date of occurrence April 7-1945
(c) Where did injury occur? Portageville New Madrid, Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home

While at work? No (Specify type of place) _____
(e) Means of injury Hit with ax
23. Signature Geo Hedgworth Coroner
(M. D. or other) _____
Address New Madrid, Mo Date signed 4/8-45

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

RECEIVED

District Health Office No. 2

District File Number 545-643

Date Filed 3-7-45

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

Jack Kelley

Licensed Embalmer No.

3788

P. O. Address

Hayt, 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. *May*
Registrar's No. *238*

Registration District No. *241*

Primary Registration District No. *4360*

1. PLACE OF DEATH:

(a) County *New Madrid*
(b) City or town *Portageville*
(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)

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 _____

3. (a) PRINT FULL NAME *Icey Arnold*

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex *F* 5. Color or race *B* 6. (a) Single, widowed, married, divorced *S.*

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

7. Birth date of deceased *May 2 1945*
(Month) (Day) (Year)

8. AGE: Years *43* Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) *(Ellen DeLusk)*
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ year *1945* hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration

Due to _____

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 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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

140604