S. No. 2
M—8-43
5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 1 · 1945

Registration District No. 2-4

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17879

State File No.

Primary Registration District No. 3056

Registrar's No. 85

1. PLACE OF DEATH:
(a) County Randolph
(b) City or town Moberly
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution 709 S. 6th
(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 Randolph
(c) City or town Moberly
(If outside city or town limits, write "RURAL")
(d) Street No. 709 S. Sixth St
(If rural, give location)
(e) Citizen of foreign country? O (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Mallie Arnold
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Female
5. Color or race col
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Roy Arnold
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Oct 9 1886
(Month) (Day) (Year)

8. AGE: Years 59 Months 6 Days 3 If less than one day hr. min.

9. Birthplace (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Housewife
11. Industry or business

MOTHER FATHER
12. Name Taylor Pitts
13. Birthplace (City, town, or county) Mo (State or foreign country)
14. Maiden name Betty Higbee
15. Birthplace (City, town, or county) Mo (State or foreign country)

16. (a) Informant Christene Arthur
(b) Address 709 S. Sixth
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 6 1945
(Month) (Day) (Year)
(c) Place: burial or cremation Moberly Mo
18. (a) Signature of funeral director E. L. Orr
(b) Address Moberly Mo
19. (a) 5-5-45 (Date received local registrar) (b) Irma Hare (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 6 no
year 1945 hour 10 minute P M.

21. I hereby certify that I attended the deceased from 6-15, 1944 to 5-2, 1945
that I last saw her alive on 5-2 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Apoplexy	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy none

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?
(Specify type of place)
While at work? (e) Means of injury O

23. Signature A. A. Williams (M. D. or other) M.D.
Address Moberly Mo Date signed 5-5-45

1036

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 6-45-974
Date Filed JUN 12 1945

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 Robert L. Carr

Licensed Embalmer No. 3190

P. O. Address Moberly 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.