

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24733

FILED JUL 26 1945
Registration District No. _____

Primary Registration District No. 5983

State File No. _____

Registrar's No. 60

1. PLACE OF DEATH:

(a) County Pulaski
(b) City or town Morgan Heights, Mo. (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 Linues Clifford Arens

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

4. Sex Male 5. Color or race White 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 9 23 1894
(Month) (Day) (Year)

8. AGE: Years 50 Months 11 Days 9 If less than one day _____ hr. _____ min.

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

10. Usual occupation Filling Station Operator

11. Industry or business _____

MOTHER FATHER { 12. Name Albert Arens
13. Birthplace Holland 4
(City, town, or county) (State or foreign country)
14. Maiden name Mary Clarkin
15. Birthplace Wisconsin
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Susan E. Robbins

(b) Address Morgan Heights, Missouri

17. (a) Removal (b) Date thereof 7/8/1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Bay Wisconsin

18. (a) Signature of funeral director Fred H. Gilbert

(b) Address Dixon, Missouri

19. (a) 7-24-1945 (b) Chas M. Dodd
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pulaski 85
(c) City or town Morgan Heights, Mo. 0
(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 7 day 2
year 1945 hour 10 minute 30 P.M.

21. I hereby certify that I attended the deceased from Jan 1941
July 2 1945 to July 2 1945
that I last saw him alive on July 2 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration _____

Due to Hypertensive Heart Disease

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 R O Odeh (M. D. or other) 26
Address Raymerville, Mo Date signed 7-21-45

(Licensed Embalmer's Statement on Reverse Side)

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

1111 27 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
July 2 - 1945, Registered Apprentice No. _____
working under my personal supervision.

Signed Fred H. Gillman

Licensed Embalmer No. 2341

P. O. Address Dixon, Missouri

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.