

No. 2
-2.43
-17.39
X23697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Don't Kerr
27349
State File No. _____
Registrar's No. 622

FILED AUG 29 1945
Registration District No. 125

Primary Registration District No. 2000

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

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
230 W. Court
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None (Specify whether
In this community 35 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39
(c) City or town Springfield 2
(If outside city or town limits, write "RURAL")
(d) Street No. 230 W. Court 6
(If rural, give location)
(e) Citizen of foreign country? 0 or No)
If yes, name country _____

3. (a) PRINT FULL NAME Frances Ada Arnold

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Howard Arnold 6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased August 3 1859
(Month) (Day) (Year)

8. AGE: Years 86 Months 0 Days 4 If less than one day
hr. min.

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

10. Usual occupation Housewife

11. Industry or business In Home

12. Name Unknown Carr

13. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. R. C. Hunter

(b) Address Springfield, Missouri

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

(c) Place: burial or cremation East Lawn Cemetery

18. (a) Signature of funeral director Alma Lohmeyer Funeral Home

(b) Address Springfield, Missouri

19. (a) 8-8-45 (b) W. J. Houdley
(Date received local registrar) (Registrar's signature)

20. DATE OF DEATH: Month August day 7th,
year 1945 hour 6:30 minute A. M.

21. I hereby certify that I attended the deceased from July 12 - 21,
1945, to Aug 7, 1945,
that I last saw her alive on Aug 7, 1945,
and that death occurred on the date and hour stated above.

Immediate cause of death Kidney Trouble
Bright Disease

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 7th,
year 1945 hour 6:30 minute A. M.

21. I hereby certify that I attended the deceased from July 12 - 21,
1945, to Aug 7, 1945,
that I last saw her alive on Aug 7, 1945,
and that death occurred on the date and hour stated above.

Immediate cause of death Kidney Trouble
Bright Disease

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy no

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no

(b) Date of occurrence _____

(c) Where did injury occur? no
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(e) While at work? no (Specify type of place)

(f) Means of injury _____

23. Signature U. F. Kerr (M. D. or other)

Address 636 E Grand Date signed Aug

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 L. A. Roof

Licensed Embalmer No. 3055

P. O. Address Springfield 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.

X

D
45
X43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Sept
622
Registrar's No. 622

Registration District No. 128

Primary Registration District No. 2000

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Frances Ada Arnold

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

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced wid

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

7. Birth date of deceased Aug 3 (Month) (Day) (Year)

8. AGE: Years 86 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 _____

MOTHER, FATHER { 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) _____ (Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____ Year 1945 Hour _____ minute _____ M.

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

Due to _____

Due to chronic lung stasis

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____ Of autopsy 13W
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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 J F Kern (M. D. or other) _____
Address Springfield Date signed _____

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

SUPPLEMENTARY

S-27349