

No. 2
-8-13
-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **5442**
Registrar's No. **1**

FILED FEB 19 1946

Registration District No. **4232** Primary Registration District No. **4232**

1. PLACE OF DEATH:

(a) County **HOWELL**
(b) City or town **WILLOW SPRINGS**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **50 YEARS** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **MARTHA JAMES ARELL**

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

4. Sex **F** 1 5. Color or race **W** 6. (a) Single, widowed, married, divorced **W** 2
6. (b) Name of husband or wife **JOSEPH A. ARELL** 6. (c) Age of husband or wife if alive, years **14**
7. Birth date of deceased **JUNE 14 1859** (Month) (Day) (Year)

8. AGE: Years **86** Months **6** Days **17** If less than one day hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business

12. Name **J. W. Hawkins** 9
13. Birthplace **unknown** (City, town, or county) (State or foreign country)

14. Maiden name **unknown** 9
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Mary Watson**
(b) Address **Willow Springs, Mo.**

17. (a) **Burial** (b) Date thereof **1-3-46** (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation **City Cemetery**

18. (a) Signature of funeral director **James Funeral Home**
(b) Address **Willow Springs, Mo.**

19. (a) **1-3-46** (b) **Thos. M. Miller** (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO.** (b) County **Howell** 46
(c) City or town **Willow Springs, Mo.** 2
(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 **Jan** day **1st**
year **1946** hour **2:15** minute **P.** M.

21. I hereby certify that I attended the deceased from **12-25-** 19**45**, to **1-1-** 19**46**

that I last saw him alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death **Broncho-pneumonia** Duration **7 days**

Con. Arteriosclerosis 10 yrs.

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy **107**

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? (c) Means of injury **1**

23. Signature **J. J. Callahan** (M. D. or other)
Address **Willow Springs** Date signed **1-3-46**

127 (Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 8
District File Number 246144
Date Filed 8.18.46

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.

Not embalmed

Signed.....

Licensed Embalmer No.....

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.