

STANDARD CERTIFICATE OF DEATH

Registration District No. 207

Primary Registration District No. 4319

State File No. _____

Registrar's No. 26

1. PLACE OF DEATH:

(a) County Maries
(b) City or town Belle
(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 18 years years, months or days

3. (a) PRINT FULL NAME

Joseph Arthur Arendall
3. (b) If veteran World War I name war / 3. (c) Social Security No. none

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Belle Arendall 6. (c) Age of husband or wife if alive 48 years
7. Birth date of deceased April 13 1887 (Month) (Day) (Year)

8. AGE: Years 57 Months 5 Days 16 If less than one day _____ hr. _____ min.

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

10. Usual occupation Barber

11. Industry or business _____

12. Name James Arendall
13. Birthplace Mo. (City, town, or country) (State or foreign country)
14. Maiden name Wardner
15. Birthplace Mo. (City, town, or country) (State or foreign country)

16. (a) Informant Mr. J. A. Arendall
(b) Address Belle - Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 2-46 (Month) (Day) (Year)

(c) Place: burial or cremation 1. DEPT

18. (a) Signature of physician Pauline Howard
(b) Address Belle - Mo.

19. (a) 10-7-46 (Date received local registrar) (b) Pauline Howard (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 29 year 1946 hour 11 minute 30 M.

21. I hereby certify that I attended the deceased from Sept 29 to Sept 29 1946
that I last saw him alive on Sept 29 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial

Due to _____

Due to _____

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

Major findings: Of operations none

Of autopsy no

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 _____

23. Signature Pauline Howard (M. D. or other)

Address Belle Mo Date signed Oct 1-46

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

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed..... 10-14-46

DEC 20 1946

OCT 18 1946

OCT 21 1946

OCT 30 1946

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.....

Chester Lassmann

Licensed Embalmer No. 4178

P. O. Address. Bland - 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.