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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 19 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40442

State File No. _____

5134

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St Joseph Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10-29-46 - 12-8-46
(Specify whether

In this community same
years, months or days Dallas

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

(c) City or town Sparta
(If outside city or town limits, write "RURAL")

(d) Street No. Star B.
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Arms, Merwin B. (Data)

3. (b) If veteran, name war no

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 8 year 46 hour 2 minute 50 M.

21. I hereby certify that I attended the deceased from 10-24-
1946 to 12-8-
1946

that I last saw h. or. alive on 12-7-46
and that death occurred on the date and hour stated above.

4. Sex Female

5. Color or race white

6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife Arms, Merwin B.

6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased: Feb 28 1885
(Month) (Day) (Year)

Immediate cause of death Cerebrovascular
failure

Duration _____

8. AGE: Years 61 Months 9 Days 10 If less than one day hr. min.

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

10. Usual occupation housewife

Due to Removal of hyper-nephrom

Due to marked secondary anemia

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

MOTHER FATHER

11. Industry or business _____

12. Name Abner J. Sully

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

14. Maiden name Mary Elizabeth Coats

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

Major findings: Of operations muscular tumor firm Red, size just tall

Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant Arms, Merwin B.

(b) Address Sparta Mo

17. (a) Removal (b) Date thereof 12-7-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Breckenridge Mo

18. (a) Signature of funeral director Cramer, Clark

(b) Address Kingston Mo

19. (a) 12-7-46 (b) Theraldine Holmes
(Date received local registrar) (Registrar's signature)

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 W. J. Jones (M. D. or other) _____
Address Trust Bldg Date signed 12-8-46

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

STATE 7 BL. 10/10/2000

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 Cramer Clark

Licensed Embalmer No. 3257

P. O. Address Kingston 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.

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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 5134

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Joseph
(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 Della Arns

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

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

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

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years _____ 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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 12-7-46 (b) Deraldine Holmes
(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 Dec Day 7 Year 1946 Hour 2 minute 15 AM.

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

Immediate cause of death _____

Circulatory failure

Due to removal of hypernephroma

Due to marked secondary anemia

Other conditions _____ (Include pregnancy within 3 months of death) 520

Major findings: massive tumor from red, size football.

Of autopsy _____

Duration _____
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 _____

Signature H. S. Jones (M. D. or other) _____

Address Bryant Bldg Date signed 12-8-47

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—PERMANENT RECORD

40442