

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED MAR 21 1947

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No.

43773

Registration District No. 12

Primary Registration District No. 5052

Registrar's No.

1. PLACE OF DEATH:

(a) County Barry  
(b) City or town Eagle Rock  
(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 years, months or days)

3. (a) PRINT FULL NAME Harriet Olive Arnold

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

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Jesse H. Arnold 6. (c) Age of husband or wife if alive 39 years  
7. Birth date of deceased September 13 1907  
(Month) (Day) (Year)

8. AGE: Years 39 Months 2 Days 18 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Albert Castor  
13. Birthplace Wisconsin  
(City, town, or county) (State or foreign country)  
14. Maiden name Dosha Cardell  
15. Birthplace North Carolina  
(City, town, or county) (State or foreign country)

16. (a) Informant Jesse H. Arnold  
(b) Address Eagle Rock, Missouri  
17. (a) Burial (b) Date thereof 12-4-1946  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Oak Hill Cemetery

18. (a) Signature of funeral director Culver Funeral Home  
(b) Address Cassville, Missouri  
19. (a) 1-11-47 (b) Jesse Hudson  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Barry 5  
(c) City or town Eagle Rock 0  
(If outside city or town limits, write "RURAL") 0  
(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 December day 1st  
year 1946 hour 11:30 minute P. M.

21. I hereby certify that I attended the deceased from Nov. 30 1946 to DEC. 1 1946  
that I last saw her alive on DEC. 1 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Primary Anemia Duration \_\_\_\_\_

Due to \_\_\_\_\_  
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 0  
23. Signature Glenn H. Dwyer M.D. (S.D. or other)  
Address Cassville, Mo Date signed 12/10/46

APR 18 1947

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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 Margaret Culver  
Licensed Embalmer No. 4389  
P. O. Address Cassville

**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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No.

*April*

Registration District No.

*12*

Primary Registration District No.

*5052*

Registrar's No.

1. PLACE OF DEATH:

- (a) County *Barry*  
(b) City or town *Eagle Rock*  
(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

*Harriet O 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

6. (b) Name of husband or wife

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

7. Birth date of deceased

*Sept 13 1901*  
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

Unless than one day

*39*

*2*

*mo*

9. Birthplace

(City, town, or county)

(State or foreign country)

10. Usual occupation

11. Industry or business

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)

(Burial, cremation, or removal)

(b) Date thereof

(Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a)

(Date received local registrar)

(b)

*Mrs. Helen Hudson*  
(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 *April*  
year *1946* hour minute M.

21. I hereby certify that I attended the deceased from  
to  
that last saw him alive on  
and that death occurred on the date and hour stated above.  
Immediate cause of death

Duration

Due to

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 sta-  
tistically.

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 (M. D. or other)

Address Date signed

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

SUPPLEMENTARY

S-43773