

FILED JAN 30 1947

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

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1. PLACE OF DEATH

County Bates
Township Maund
City Adrian (No. _____, St. _____, Ward _____)

Registration District No. 20
Primary Registration District No. 5083

File No. _____
Registered No. _____

2. FULL NAME

Addie Arganbright
(a) Residence, No. _____, St. _____, Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 26 - 1873

7. AGE YEARS 74 MONTHS 4 DAYS 28 IF LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. House Wife
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bates Co. Mo.

13. NAME Jake Speak

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Adrian Mo.

15. MAIDEN NAME Mauda Standish

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Adrian Mo.

17. INFORMANT (ADDRESS) Addie Arganbright

18. BURIAL, CREMATION, OR REMOVAL PLACE Adrian DATE 1/26, 1947

19. UNDERTAKER (ADDRESS) Myra Owens

20. FILED 1-22, 1947 Myra Owens Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 23, 1947

22. I HEREBY CERTIFY, that I attended deceased from Jan 19, 1946, to Jan 23, 1947

I last saw him alive on Jan 19, 1947. Death is said to have occurred on the date stated above, at 11 A. m.

The principal cause of death and related causes of importance were as follows:

hypertension
Date of onset _____
Other contributory causes of importance: Arteriosclerosis

Name of operation none Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? no Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury none
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify _____
(Signed) E. E. Rhine, M. D.
(Address) Adrian Mo.

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *721*

Registration District No. *20*

Primary Registration District No. *5083*

Registrar's No. _____

1. PLACE OF DEATH:

(a) County *Bates*
(b) City or town *Rural*
(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

addie Arganbreght

3. (b) If veteran,
name war _____

3. (c) Social Security
No. _____

4. Sex *F* 5. Color or race *w.*
6. (a) Single *wid* 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 *aug 26*
(Month) (Day) (Year)

8. AGE: Years *74* Months _____ Days _____ Less than one day
hr. _____ min. _____

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) _____ (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 _____ Year *1947* 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 _____

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 *E. E. Robinson* (M. D. or other) _____

Address *Adrian, Mo.* Date signed _____

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

SUPPLEMENTARY

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