

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED APR 1 1947**

THE STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

State File No. **8500**  
Registrar's No. **9**

Registration District No. **109**

Primary Registration District No. **4180**

**1. PLACE OF DEATH:**

(a) County **Dunklin**  
(b) City or town **Campbell**  
(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  
In this community **40 years**  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Mary Ella Archart**

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 **J. E. Archart**  
6. (c) Age of husband or wife if alive **79** years  
7. Birth date of deceased **November 29 1872**  
(Month) (Day) (Year)

8. AGE: Years **74** Months **3** Days **20**  
If less than one day hr. min.

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

10. Usual occupation **Housewife**

**11. Industry or business**

12. Name **Daniel Stowers**  
13. Birthplace **Unknown**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Unknown**  
15. Birthplace **Unknown**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Chas. P. Adams**  
(b) Address **Piggott, Ark.**  
17. (a) **Burial** (b) Date thereof **3-21-47**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **New Hope Cemetery**

18. (a) Signature of funeral director **Chas. P. Adams**  
(b) Address **Piggott, Ark.**  
19. (a) **3/29/47** (b) **Mrs. Daniel Campbell**  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **Ark** (b) County **Clay**  
(c) City or town **Piggott**  
(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 **3** day **19**  
year **47** hour **9** minute **07 P.M.**

21. I hereby certify that I attended the deceased from **March 16, 1947** to **March 19, 1947**  
that I last saw her alive on **March 19, 1947**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Lobar Pneumonia** Duration **3 days**

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?

(Specify type of place)  
While at work? (c) Means of injury **2**  
23. Signature **Dr. B. L. Franklin** or other  
Address **Campbell, Mo.** Date signed **3/22/47**

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

APR 29 1947

Dr. Franklin  
Campbell, Mo.

RECEIVED

District Health Office No. 2,

District File Number 447-462

Date Filed 4-3-47

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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.....

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.**