

State File No. **26663**
Registrar's No. **125**

FILED AUG 27 1947
Registration District No. **3002**

Primary Registration District No. **3002**

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

1. PLACE OF DEATH:

(a) County **Audrain**
(b) City or town **Mexico**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
603 N. Jefferson St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community **25 years**
years, months or days)

3. (a) PRINT FULL NAME **Thomas Jefferson Arnold**

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

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **M**
6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive years

7. Birth date of deceased **March 27, 1865**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
82 4 16 hr. min.

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

10. Usual occupation **Retired Farmer**

11. Industry or business

12. Name **James E. Arnold**

13. Birthplace **Ind.**
(City, town, or county) (State or foreign country)

14. Maiden name **Elizabeth Kreuson**
15. Birthplace **Ind.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. T. J. Arnold**

(b) Address **Mexico, Mo.**

17. (a) **Burial** (b) Date thereof **8/14/47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Elmwood, Mexico, Mo.**

18. (a) Signature of funeral director **Chris Arnold**

(b) Address **Mexico, Mo.**

19. (a) **8/14/47** (b) **Blanche Kelly**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Audrain**
(c) City or town **Mexico**
(If outside city or town limits, write "RURAL")
(d) Street No. **603 N. Jefferson**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **13**
year **1947** hour **1** minute **00** A.M.

21. I hereby certify that I attended the deceased from **4/24/46**
to **Aug 13 1947**
that I last saw him alive on **Aug 12 1947**
and that death occurred on the date and hour stated above.

Immediate cause of death

Uremia Duration **6 mos**

Due to **Chronic cardiac vascular** 10 yrs

Due to **renal disease**

Emphysema

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **731A**

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) (c) Means of injury

23. Signature **C. L. Harris** (M. D. or other)

Address **Mexico, Mo.** Date signed **8/14/47**

RECEIVED
District Health Officer No. 10
District File Number 8-47-1121
Date Filed AUG-23-1947

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.