

Registration District No. 370 Primary Registration District No. 3058

1. PLACE OF DEATH:
(a) County. STCHARLES
(b) City or town. St. Charles
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Joseph's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 hours (Specify whether years, months or days)

3. (a) PRINT FULL NAME Mrs. Cecile N. Arnold
3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female / 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Dr. Grant Arnold 6. (c) Age of husband or wife if alive ---- years
7. Birth date of deceased December 31, 1864 (Month) (Day) (Year)

8. AGE: Years 82 Months 7 Days 2 If less than one day hr. min.

9. Birthplace Portage Des Sioux Missouri (City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business

12. Name John King
13. Birthplace Not Known (City, town, or county) (State or foreign country)
14. Maiden name Louise Novall
15. Birthplace Not Known (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Julian O'Conner
(b) Address R.R. 3, St. Charles, Mo.

17. (a) Burial (b) Date thereof, Aug. 5, 1947 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation, Wellsville Cemetery, Wellsville, Mo.

18. (a) Signature of funeral director H. A. ...
(b) Address 326 N. 6th, St. St. Charles, Mo.

19. (a) Aug 31/47 (b) H. A. ... (Date received local report) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Charles 92
(c) City or town Rural 0
(If outside city or town limits, write "RURAL")
(d) Street No. R.R. 3, St. Charles 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month August day 3 year 1947 hour 9 minute 55 A.M.

21. I hereby certify that I attended the deceased from 8/3 to 8/3, 1947, that I last saw her alive on 8/3/47, and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral apoplexy? Skull fracture - Cerebral contusion Due to Fracture of Skull 8h.

Due to: Generalized arteriosclerosis? Essential hypertension? 44yr. Other conditions: old rheumatoid (Include pregnancy within 3 months of death) Cerebral arteriosclerosis

Major findings: Of operations: No Of autopsy: No

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident 9.7.1
(b) Date of occurrence 8/3/47 1-2 A.M.
(c) Where did injury occur? St. Charles County (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? home

While at work? no (Specify type of place) (e) Means of injury fall no 0
23. Signature R. O. ... (M. D. or other) Address ... Date signed 8/3/47

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

NOV 15 1947

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed SEP 17 1947

DEC 11 1948

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.