

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35119

State File No. _____

FILED NOV 7 1947
Registration District No. 2237

Primary Registration District No. 5825

Registrar's No. 119

1. PLACE OF DEATH

(a) County New Madrid
(b) City or town Lilbourn
(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

(b) If veteran _____ (c) Social Security No. _____
name war _____

4. Sex 71 5. Color or race W. 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Geo. Arnold 6. (c) Age of husband or wife if alive 2 years
7. Birth date of deceased 10 (Month) 12 (Day) 47 (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace Cairo, Ind., U.S.A. (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Geo. Arnold
13. Birthplace Stoddard Co, Mo. (City, town, or county) (State or foreign country)
14. Maiden name Edith Galt
15. Birthplace Marion, Ark. (City, town, or county) (State or foreign country)

16. (a) Informant Geo. Arnold
(b) Address Lilbourn, Mo.

17. (a) Monitors (b) Date thereof 10-3-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Hope, Ill.

18. (a) Signature of funeral director G. M. Hill

(b) Address Lilbourn, Mo.

19. (a) 10/3/47 (b) Dr. G. M. Hill
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County New Madrid
(c) City or town Lilbourn, Mo. (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 10 day 12 year 47 hour 1 minute PM M.

21. I hereby certify that I attended the deceased from 10-12-47 19____ to 10-12-47 19____; that I last saw him alive on 10-12-47 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Alcoholism

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 161 P

Major findings: Of operations _____

Of autopsy _____

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 2

23. Signature Dr. G. M. Hill (M. D. or other)

Address Lilbourn, Mo. Date signed 10/3/47

RECEIVED

District Health Office No. 2

District File Number 1147-1436

Date Filed 11-5-47

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.