. S. No. 2
0M—1/47
ev. 5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

38783

State File No.....

FILED NOV 17 1947

Registration District No. 10

Primary Registration District No. 5625

Registrar's No.....

1. PLACE OF DEATH:
(a) County Laclede
(b) City or town Lebanon Conglomerate
(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 60 yrs. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Laclede 53
(c) City or town Lebanon 0
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Mollie Arnold
3. (b) If veteran, name war.....
3. (c) Social Security No.

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife Wm. T. Arnold
6. (c) Age of husband or wife if alive 81 years
7. Birth date of deceased Sept. (Month) 25 (Day) 1864 (Year)

8. AGE: Years 82 | Months 1 | Days 5 | If less than one day ....hr. ....min.

9. Birthplace Macon Co. Mo (City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business.....

FATHER
12. Name John Hess
13. Birthplace Indiana (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace 9 (City, town, or county) (State or foreign country)

16. (a) Informant Wm. T. Arnold
(b) Address Lebanon Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 (Month) 11 (Day) 47 (Year)
(c) Place: burial or cremation Stevens
18. (a) Signature of funeral director Palmer
(b) Address Lebanon Mo
19. (a) Nov. 8, 1947 (Date received local registrar) (b) Ora Frankeberger (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 31 year 1947 hour 6 minute 35 A.M.
21. I hereby certify that I attended the deceased from Aug. 14, 1947, to Oct 31st, 1947, that I last saw h alive on Oct 31st, 1947, and that death occurred on the date and hour stated above.

Cause	Duration
Immediate cause of death: Valvular disease of the heart	Lifetime
Due to.....	
Due to.....	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN

Underline the cause of 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?..... (e) Means of injury.....

23. Signature C. E. Carlton (M. D. or other)
Address Stoutland Mo. Date signed 11-1-47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

Received 11/14/47

Lafayette County Health Unit

File No. 11-47-493

Date Filed 11/14/47

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 L. P. Palmer

Licensed Embalmer No. 2258

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.