

FILED FEB 5 1948

Registration District No.

UNITED STATES DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3054

State File No.

2005

Registrar's No.

3

1. PLACE OF DEATH

(a) County Pike
(b) City or town Remission
(c) Name of hospital or institution Pike County
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 24 Hours
(Specify whether
In this community LIFETIME
years, months or days)

3. (a) PRINT
FULL NAME

JOSEPH TRAVIS ARTHUR

3. (b) If veteran,

name war None

3. (c) Social Security No.

None

4. Sex Male Color or race White
(b) Name of husband or wife FANNIE ARTHUR
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (c) Age of husband or wife if alive 18 years
7. Birth date of deceased OCTOBER 18 1961
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
87 2 21 hr. min.

9. Birthplace Pike Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation RETIRED DRAYMAN

11. Industry or business FRUIT ETC.

12. Name JOSEPH ARTHUR

13. Birthplace UNKNOWN N. Carolina
(City, town, or county) (State or foreign country)

14. Maiden name ELIZABETH INCE

15. Birthplace UNKNOWN N. Carolina
(City, town, or county) (State or foreign country)

16. (a) Informant William Arthur

(b) Address Chicago ILL

17. (a) BURIAL (b) Date thereof 11/11/1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation River View Cemetery

18. (a) Signature of funeral director GEORGE STEIN

(b) Address LOUISIANA MISSOURI

19. (a) 1-9-48 (b) Remission Collier
(Date received local registrar) (Registrar's signature)

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Pike
(c) City or town Remission Mo
(If outside city or town limits, write "RURAL")
(d) Street No. NEAR YOUNG'S LAKE
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 9
year 1948 hour 9:00 minute PM

21. I hereby certify that I attended the deceased from 1-9-48
19....., to 1-9-48 19.....
that I last saw him alive on 1-9-48 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death MYOCARDIAL FAILURE

Due to Senility

Due to

Other conditions ARTHRITIS
(Include pregnancy within 3 months of death)

Major findings: NONE
Of operations

Of autopsy NONE 59B

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 0

23. Signature JR. Collier (M. D. or other) MD

Address Louisiana 1170 Date signed 1-9-48

PHYSICIAN

Underline the cause of which death should be charged statistically.

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

MOTHER FATHER

RECEIVED
District Health Officer No. 10
District File Number 2-11-22
Date Filed FEB -4 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
Virginia M. Stone Registered Apprentice No. 491
working under my personal supervision.

Signed

Licensed Embalmer No. 3720

P. O. Address Louisiana Mo.

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.