

FILED APR 6 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8249

BIRTH NO. _____		REG. DIST. NO. 149		PRIMARY REG. DIST. NO. 1002		Registrar's No. 1097	
1. PLACE OF DEATH a. COUNTY JACKSON				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY HARRISON			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY				c. LENGTH OF STAY (In this place) 1 day			
d. FULL NAME OF HOSPITAL OR INSTITUTION RESEARCH HOSPITAL				e. CITY (If outside corporate limits, write RURAL and give township) OR TOWN BETHANY RURAL			
d. STREET ADDRESS R.R. #1							
3. NAME OF DECEASED (Type or Print)		a. (First) CHARLES		b. (Middle) M		c. (Last) ARNOLD	
						4. DATE OF DEATH (Month) (Day) (Year) Mar 10 1949	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED		8. DATE OF BIRTH MAY 15 1876	
						9. AGE (In years last birthday) 72 YRS.	
						10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER	
						11. BIRTHPLACE (State or foreign country) BETHANY MISSOURI	
						12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME JOSEPH JOHN ARNOLD		13b. MOTHER'S MAIDEN NAME CORDelia WHITAKER		14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME JAMES F. ARNOLD		ADDRESS R.R. #3 CAMERON MO	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Peritonitis, generalized ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Perforation of Gastric Ulcer DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Semility 5401				INTERVAL BETWEEN ONSET AND DEATH 4 days years	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES ☒ NO ☐	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)		21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Mar 9, 1949, to Mar 10, 1949, that I last saw the deceased alive on Mar 9, 1949, and that death occurred at 4:32 A.M., from the causes and on the date stated above.							
23a. SIGNATURE L. C. Layton (Degree or title)				23b. ADDRESS 934 Arville Bldg		23c. DATE SIGNED Mar 10, 49	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE MAR 10 1949		24c. NAME OF CEMETERY OR CREMATORY MYRIAM CEMETERY BETHANY		24d. LOCATION (City, town, or county) (State) MISSOURI	
DATE REC'D BY LOCAL REG. 3-10-49		REGISTRAR'S SIGNATURE Geraldine Holmes		25. FUNERAL DIRECTOR'S SIGNATURE W. H. Newcomer		ADDRESS 1401 BRUN PAREN KANSAS CITY, MO	

(Licensed Embalmer's Statement on Reverse Side)

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

STANDARD CERTIFICATE OF DEATH

THE DIVISION OF HEALTH OF MISSOURI

DECEASED'S NAME LAST, FIRST, MIDDLE (If deceased was a child, give name of mother)		PLACE OF DEATH CITY, TOWN, OR VILLAGE COUNTY, STATE	
USUAL RESIDENCE CITY, TOWN, OR VILLAGE COUNTY, STATE		DATE OF DEATH MONTH, DAY, YEAR	
ADDRESS STREET, CITY, STATE, ZIP		SEX MALE FEMALE	
DATE OF BIRTH MONTH, DAY, YEAR		MARRIED, NEVER MARRIED, OR WIDOWED, DIVORCED, SEPARATED	
BIRTHPLACE CITY, TOWN, OR VILLAGE COUNTY, STATE		USUAL OCCUPATION OR BUSINESS (If deceased was a child, give name of father)	
NAME OF WIFE LAST, FIRST, MIDDLE		NAME OF HUSBAND LAST, FIRST, MIDDLE	

CAUSE OF DEATH (If deceased was a child, give name of mother)		MEDICAL CERTIFICATION (If deceased was a child, give name of mother)	
(If deceased was a child, give name of mother)		(If deceased was a child, give name of mother)	

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 _____, Student Embalmer No. _____, working under my personal supervision.

Signed _____ Student-Embalmer		Signed _____ Licensed Embalmer No. 445-3	
P. O. Address _____		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.