

FILED JUN 6 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15188

BIRTH NO. _____		REG. DIST. NO. 59		PRIMARY REG. DIST. NO. 5224		Registrar's No. 78	
1. PLACE OF DEATH a. COUNTY Cass				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY Cass			
b. CITY OR TOWN Rural Grandriver		c. LENGTH OF STAY (If in institution) 3 mi S.E. of Harrisonville		c. CITY OR TOWN Rural Grandriver		d. STREET ADDRESS (If rural, give location) 3 mi S.E. of Harrisonville	
d. FULL NAME OF HOSPITAL OR INSTITUTION Harrisonville Mo				d. STREET ADDRESS (If rural, give location) 3 mi S.E. of Harrisonville			
3. NAME OF DECEASED (Type or Print) Roxella Catherine Arnold				4. DATE OF DEATH (Month) (Day) (Year) June 1 - 1949			
5. SEX Fe		6. COLOR OR RACE wh		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, SEPARATED widowed		8. DATE OF BIRTH Sept 7 1886	
9. AGE (In years, last birthday) 62		10. SEX 8		11. BIRTHPLACE (State or foreign country) Cass Co. Mo.		12. CITIZEN OF WHAT COUNTRY USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, and if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY ✓			
13a. FATHER'S NAME Elijah Shingleton		13b. MOTHER'S MAIDEN NAME Sarah Keith		14. NAME OF HUSBAND OR WIFE John W. Arnold			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Willber Arnold Peculiar			
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) Strangulation by Hanging ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 5174X			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES ☐ NO ☒			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) Suicide		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Harrisonville Cass Mo		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) June 1 - 1949 P.M.	
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒		21f. HOW DID INJURY OCCUR? Rope Around Neck					
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) H. J. Smith, Acting Coroner				23b. ADDRESS Harrisonville Missouri		23c. DATE SIGNED June 3-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE June 3-49		24c. NAME OF CEMETERY OR CREMATORY Orient Cem.		24d. LOCATION (City, town, or county) (State) Harrisonville Mo.	
DATE REC'D BY LOCAL REG. June 3-1949		REGISTRAR'S SIGNATURE Laura J. Jones		25. FUNERAL DIRECTOR'S SIGNATURE William J. Jones		ADDRESS Harrisonville Mo.	

(Licensed Embalmer's Statement on Reverse Side)

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

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, Bill J. Shiley

Student Embalmer No. 254

working under my personal supervision.

Student Bill J. Shiley.....
Student Embalmer

Signed David H. Johnson

Licensed Embalmer No. 3900

P. O. Address Johnsonville

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.

No