

FILED JUN 16 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 20494

No. 300  
10-48

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

BIRTH NO. REG. DIST. NO. 274 PRIMARY REG. DIST. NO. 3052 Registrar's No. 186

1. PLACE OF DEATH a. COUNTY <b>Pettis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Pettis</b>	
b. CITY (If outside corporate limits, write RURAL and give town) <b>Sedalia</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Sedalia</b>	
c. LENGTH OF STAY (In this place) <b>57 yrs.</b>		d. STREET ADDRESS (If rural, give location) <b>1705 E. 6th St.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Bothwell Hospital</b>			

3. NAME OF DECEASED (Type or Print) <b>ARTHUR</b>	a. (First)	b. (Middle) <b>W.</b>	c. (Last) <b>RENNICKS</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>June 4, 1949</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>July 21, 1872</b>	9. AGE (In years last birthday) <b>76</b>	IF UNDER 1 YEAR Months <b>10</b> Days <b>13</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Custodian Masonic Temple.</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Temple.</b>	11. BIRTHPLACE (State or foreign country) <b>Quebec, Montreal, Providence Canada</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>Unknown</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Carrie Elizabeth Thorne</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>----</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Miss Jennie Tooker, Sedalia, Mo.</b>	ADDRESS <b>Sedalia, Mo.</b>
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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		INTERVAL BETWEEN ONSET AND DEATH <b>to June 3, 1949.</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral hemorrhage, right side, May, 3, 1949.</b>		
	ANTECEDENT CAUSES <b>Again on June, 3, 1949.</b> Morbid conditions, if any, giving rise to the above cause (a), stating the underlying cause last. DUE TO (b) <b>Nephritis, arterio sclerosis, hypertension, etc.</b> DUE TO (c) <b>Senile changes beginning to show.</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>As above.</b>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>No operation,</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>No accident.</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>No injury.</b>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>XXXX XXXX XXXX</b>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>No injury.</b>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>No injury.</b>
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22. I hereby certify that I attended the deceased from **May, 3, 1949**, to **June, 3, 1949**, that I last saw the deceased alive on **June 3, 1949**, and that death occurred at **12:40 P.M.** from the causes and on the date stated above.

23a. SIGNATURE <b>C. J. Prader, M.D.</b>	23b. ADDRESS <b>112 West 4th Street, Sedalia, Mo.</b>	23c. DATE SIGNED <b>June 6, 1949.</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>June 7, 1949</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Crown Hill</b>	24d. LOCATION (City, town, or county) (State) <b>Sedalia, Missouri</b>
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DATE REC'D BY LOCAL REG. <b>6/7/49</b>	REGISTRAR'S SIGNATURE <b>Betty Yeager</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>251</b>	ADDRESS <b>Sedalia</b>
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(Licensed Embalmer's Statement on Reverse Side)

JUN 13 RECD  
RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 6-15-49

JUN 28 1949

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 \_\_\_\_\_

RICHARD D. CONN

Student Embalmer No. 261

working under my personal supervision.

Signed

Richard D. Conn  
Student Embalmer

Signed

Warrent Dietz

Licensed Embalmer No. 4583

P. O. Address Idalea, 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.