

FILED JUL 16 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22896

State File No.

BIRTH NO. _____ REG. DIST. NO. 82 PRIMARY REG. DIST. NO. 3017 Registrar's No. 83

1. PLACE OF DEATH a. COUNTY <u>COOPER</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>COOPER</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>BOONVILLE</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>BOONVILLE</u>	
c. LENGTH OF STAY (in this place) <u>3 hrs</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. JOSEPH'S HOSPITAL</u>		d. STREET ADDRESS (If rural, give location) <u>7th & Rice ST.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>MARY</u> b. (Middle) <u>ARNOLD</u> c. (Last) _____	4. DATE OF DEATH (Month) (Day) (Year) <u>JULY 4 - 1949</u>
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>MAY 2 - 1889</u>	9. AGE (In years last birthday) <u>60.</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 11 HRS. Hours _____ Mins. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (State or foreign country) <u>COOPER COUNTY MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>WILLIAM H. LARIMORE</u>	13b. MOTHER'S MAIDEN NAME <u>AMANDA LARIMORE</u>	14. NAME OF HUSBAND OR WIFE <u>HENRY E. ARNOLD</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>HENRY E. ARNOLD</u>	ADDRESS <u>BOONVILLE - MO.</u>
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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 <u>3 hrs.</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u>		Interval between onset and death <u>unknown</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertensive cardio-vascular disease</u> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			<u>442X</u>

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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) _____
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from July 4, 1949, to July 4, 1949 that I last saw the deceased alive on July 4, 1949, and that death occurred at 5:15 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>A. Nelsman M.D.</u>	23b. ADDRESS <u>329 Main Boonville Mo</u>	23c. DATE SIGNED <u>7-5-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>JULY 6-1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>HOPEWELL CEMETERY</u>	24d. LOCATION (City, town, or county) (State) <u>COOPER COUNTY - MISSOURI</u>
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DATE REC'D BY LOCAL REG. <u>Jul 5-49</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>	ADDRESS <u>STEGNER FUNERAL HOME - BOONVILLE</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED JUL 11

District Health Officer No. 83

District File Number _____

Date Filed 7-15-49

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 _____

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

Signed.....
Student Embalmer

Signed James W. Stegner
Licensed Embalmer No. 3790

P. O. Address BOONVILLE - 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.