

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

23235

State File No. _____

BIRTH NO. _____		REG. DIST. NO. <u>141</u>		PRIMARY REG. DIST. NO. <u>3025</u>		Registrar's No. <u>72</u>	
1. PLACE OF DEATH a. COUNTY <u>HOWELL</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>HOWELL</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>WEST PLAINS</u>		c. LENGTH OF STAY (In this place) <u>30 YEARS</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>WEST PLAINS</u>		d. STREET ADDRESS (If rural, give location) <u>520 LYDEA AVE.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>USUAL RESIDENCE 520 Lydea Ave</u>				d. STREET ADDRESS (If rural, give location) <u>520 LYDEA AVE.</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>MARY</u>		b. (Middle) <u>MATILDA</u>		c. (Last) <u>ARNOLD</u>	
4. DATE OF DEATH		Month <u>JUNE</u>		Day <u>22</u>		Year <u>1949</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>		8. DATE OF BIRTH <u>JAN. 1, 1859</u>	
9. AGE (In years last birthday) <u>90</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Thomasville, MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>ABNER BIRCHETT</u>		13b. MOTHER'S MAIDEN NAME <u>POLLY SMITH</u>		14. NAME OF HUSBAND OR WIFE <u>E. D. ARNOLD</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>CHARLES ARNOLD, 520 LYDEA AVE, WEST PLAINS, MO.</u>			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic myocarditis</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>42 21</u>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR			
22. I hereby certify that I attended the deceased from <u>1/12</u> , 19 <u>49</u> , to <u>6/22</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>6/21</u> , 19 <u>49</u> , and that death occurred at <u>7:30 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>C. Balligan</u> (Degree or title) <u>M. D.</u>				23b. ADDRESS <u>West Plains, Missouri</u>		23c. DATE SIGNED	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>JUNE 24, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN CEM.</u>		24d. LOCATION (City, town, or county) (State) <u>WEST PLAINS, MO</u>	
DATE REC'D BY LOCAL REG. <u>6-30-49</u>		REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Hal Thompson</u> ADDRESS <u>West Plains, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED 7/5/49

District No. 8

District File No. 74949

Date Filed 7-14-49

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

Signed _____
Student Embalmer

Licensed Embalmer No. 3408

P. O. Address West Plains, 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.