

FILED SEP 7 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 28959

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BIRTH NO. _____		REG. DIST. NO. <u>219</u>		PRIMARY REG. DIST. NO. <u>4468</u>		Registrar's No. <u>51</u>	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission).			
a. COUNTY <u>Ste. Genevieve</u>		b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Marys</u>		a. STATE <u>Missouri</u>		b. COUNTY <u>Ste. Genevieve</u>	
c. LENGTH OF STAY (in this place) <u>1</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Marys</u>		c. CITY OR TOWN <u>St. Marys</u>		95 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION				d. STREET ADDRESS (If rural, give location) <u>2</u>			
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)				
a. (First) <u>JOSEPHINE</u>	b. (Middle) <u>ELIZABETH</u>		c. (Last) <u>ARBUCKLE</u>			4. DATE OF DEATH <u>AUG. 20 1949</u>	
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>NOV. 16 1869</u>		9. AGE (In years last birthday) <u>79</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MINE LA MOTTE MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>ELI CALLIOTE</u>		13b. MOTHER'S MAIDEN NAME <u>LAURA MISPLAY</u>		14. NAME OF HUSBAND OR WIFE <u>WILLIAM ARBUCKLE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME <u>Augustine Arbuckle</u> ADDRESS <u>2336 Sullivan Ave St. Louis Mo</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Myocarditis</u>				<u>5y 15</u>	
		ANTECEDENT CAUSES					
		DUE TO (b) <u>NONE</u>					
		DUE TO (c) <u>NONE</u>					
		II. OTHER SIGNIFICANT CONDITIONS				<u>4222</u>	
		Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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>Feb 16 1948</u> , to <u>Aug 20 1949</u> , that I last saw the deceased alive on <u>Aug 19 1949</u> , and that death occurred at <u>7:30 A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Arthur E. Seiferman M.D.</u>				23b. ADDRESS <u>566. Genesive Mo</u>		23c. DATE SIGNED <u>Aug 20 1949</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>AUG 21 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>VALLE SPRING</u>		24d. LOCATION (City, town, or county) (State) <u>STE. GENEVIEVE MO</u>	
DATE REC'D BY LOCAL REG. <u>Aug 27 1949</u>		REGISTRAR'S SIGNATURE <u>L. D. Karl</u>		FUNERAL DIRECTOR'S SIGNATURE <u>Leslie Barber</u>		ADDRESS <u>Ste. Genevieve Mo</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

8-26-49

District Health Officer No. 4  
District File Number 849-1141  
Date Filed \_\_\_\_\_

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 \_\_\_\_\_

*Alvin J. Eller*

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 4740

P. O. Address St. Genevieve, 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.