

FILED NOV 28 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 36907
Registrar's No. 1027

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY GREENE	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SPRINGFIELD		c. LENGTH OF STAY (in this place)	
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SPRINGFIELD		d. STREET ADDRESS (If rural, give location) 1320 W. THOMAN	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1320 W. THOMAN			
3. NAME OF DECEASED (Type or Print) a. (First) RACHEL b. (Middle) ELIZABETH c. (Last) JACKSON		4. DATE OF DEATH (Month) (Day) (Year) Nov. 24 1949	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH 6 DEC. 1870
9. AGE (In years last birthday) 79		IF UNDER 1 YEAR Months	IF UNDER 4 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY IN HOME	11. BIRTHPLACE (State or foreign country) MISSOURI
12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME GEORGE ARNHART		13b. MOTHER'S MAIDEN NAME MARY SCOTT	14. NAME OF HUSBAND OR WIFE DECEASED
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	17. INFORMANT'S SIGNATURE OR NAME ADDRESS ERNEST JACKSON SPCFD. Mo.
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ch. Myocardial Disease - ANTECEDENT CAUSES:- Morbid conditions, if any, giving rise to the above cause (a), stating the underlying cause last. DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Atypical Pneumonia	
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 <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 11-10 1949, to 11-24 1949, that I last saw the deceased alive on 11-22 1949, and that death occurred at 4:30A m., from the causes and on the date stated above.			
23a. SIGNATURE Max Ditch (Degree or title) M.D.		23b. ADDRESS Springfield Mo	23c. DATE SIGNED 11-25-49
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 26 Nov. 1949	24c. NAME OF CEMETERY OR CREMATORY KINGS POINT CEME.	24d. LOCATION (City, town, or county) (State) MONETT Mo.
DATE REC'D BY LOCAL REG 11-26-49	REGISTRAR'S SIGNATURE W. G. Handley	11 FUNERAL DIRECTOR'S SIGNATURE J. W. Klingner & Co.	ADDRESS SPCFD. Mo.

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

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F. 11-26-49

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. 4071

P. O. Address Springfield

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.