

FILED DEC 10 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 37742

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BIRTH NO. 124 REG. DIST. NO. 163 PRIMARY REG. DIST. NO. 3031 Registrar's No. 63

1. PLACE OF DEATH a. COUNTY <u>Jefferson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Jefferson</u>	
b. CITY (If outside corporate limits, write RURAL, and give township) <u>De Soto</u>		c. CITY (If outside corporate limits, write RURAL, and give township) <u>De Soto</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>424 Flucom, road.</u>		d. STREET ADDRESS (If rural, give location) <u>424 Flucom, road.</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mary</u> b. (Middle) <u>Mae</u> c. (Last) <u>Arnett</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>11-25-'49</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED NEVER MARRIED, WIDOWED DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>May 3rd 1873</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Fredericktown, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13a. FATHER'S NAME <u>Joseph W^m Bennett</u>		13b. MOTHER'S MAIDEN NAME <u>Fannie Henderson</u>	
14. NAME OF HUSBAND OR WIFE <u>Lewis Arnett</u>		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>Mrs. Lola Byrd</u> ADDRESS <u>De Soto, 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchio-Pneumonia</u> ANTECEDENT CAUSES DUE TO (b) <u>Cerebral hemorrhage</u> DUE TO (c) <u>arteriosclerosis (Gen.)</u> II. OTHER SIGNIFICANT CONDITIONS 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 ☐ NO ☒		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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	
21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from <u>21 Oct, 1949</u> , to <u>25 Nov, 1949</u> , that I last saw the deceased alive on <u>24 Nov, 1949</u> , and that death occurred at <u>3:45 A.M.</u> , from the causes and on the date stated above.	
23a. SIGNATURE <u>Harold V. Neff</u> (Degree or title) <u>U.M.D.</u>		23b. ADDRESS <u>De Soto, Mo.</u>	
23c. DATE SIGNED <u>25 Nov 49</u>		24a. (BURIAL) CREMATION, REMOVAL (Specify) <u>BURIAL</u>	
24b. DATE <u>11-27-'49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Park</u>	
24d. LOCATION (City, town, or county) (State) <u>De Soto, Mo.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. Lee Motherhead</u> ADDRESS <u>De Soto, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>12/2/49</u>		REGISTRAR'S SIGNATURE <u>Marie Farrer</u> <u>146</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

JAN 4 1950

JEFFERSON COUNTY HEALTH DEPT.
HILLSBORO, MISSOURI

DATE RECEIVED 12-6-49

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.

Student
Student Embalmer

Signed Andrew H. England

Licensed Embalmer No. 4745

P. O. Address De Soto, 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.