

State File No. _____

FILED MAR 15 1950

Registrar's No. 64

BIRTH NO. _____ REG. DIST. NO. 294 PRIMARY REG. DIST. NO. 3056 Registrar's No. 64

1. PLACE OF DEATH	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
-------------------	---

a. COUNTY Randolph a. STATE Missouri b. COUNTY Randolph

b. CITY (If outside corporate limits, write RURAL and give township) OR	c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR
--	-----------------------------------	--

TOWN Moberly TOWN Moberly 0883

d. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

INSTITUTION <u>Whiteaker Hospital</u>			<u>201 Hagood</u>		
3 NAME OF	a. (First)	b. (Middle)	c. (Last)	4 DATE	(Month) (Day) (Year)

1. NAME OF DECEASED (Type or Print)	2. (Last)	3. (First)	4. DATE OF DEATH (Month) (Day) (Year)
Charles	Matthew	Arnold	March 6, 1950

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED	8. DATE OF BIRTH	9. AGE (In years)	IF UNDER 1 YEAR	IF UNDER 24 HRS
--------	------------------	--	------------------	-------------------	-----------------	-----------------

Male	White	WIDOWED, DIVORCED (Specify) Widowed	Jan 16 th 18 08	82	1 20		
------	-------	--	----------------------------	----	------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
---	-----------------------------------	---	------------------------------

Rtd. Farmer			mo
12. FATHER'S NAME	13. FATHER'S BIRTH DATE	14. NAME OF MARRIAGE CONTRACT	

13a. FATHER'S NAME M. J. J. J.	13b. MOTHER'S MAIDEN NAME J. J. J. J.	14. NAME OF HUSBAND OR WIFE J. J. J. J.
-----------------------------------	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES?	16. SOCIAL SECURITY	17. INFORMANT'S SIGNATURE OR NAME	ADDRESS
---	---------------------	-----------------------------------	---------

(Yes, no, or unknown) ☒	(If yes, give war or dates of service) ☒	✓	NO.	Mrs. Julia Miller. Mother of me
---	--	---	-----	---------------------------------

18. CAUSE OF DEATH		MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION		1 0 1	

1. DISEASE OR CONDITION
DIRECTLY LEADING TO DEATH* (a) arthostatic pneumonia

*This does not mean

the mode of dying, such as heart failure, anæmia.

etc. It means the dis-
tance driven or travelled
the underlying cause last.

DUE TO (c)

case, injury, or compensation which caused death.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.	1493X
--	--------------

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?

										YES	☐	NO	☐
21. ACCIDENT	22. DATE	23. PLACE OF INJURY	24. CITY/TOWN OR TOWNSHIP	(COUNTY)	(STATE)								

21A. ACCIDENT SUICIDE HOMICIDE	(Specify)	21B. PLACE OF INJURY (s.g., in or about home, farm, factory, street, office bldg., etc.)	21C. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
--------------------------------------	-----------	---	--------------------------------	----------	---------

21d. TIME	(Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
-----------	---------	-------	--------	--------	----------------------	----------------------------

OF INJURY

m. WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from July 15, 1949, to March 7, 1950, that I last saw the deceased

alive on march 6, 1952, and that death occurred at 2:22 P. m., from the causes and on the date stated above.

23a. SIGNATURE *[Signature]* (Degree or title) *[Blank]* 23b. ADDRESS *[Blank]* 23c. DATE SIGNED *3/8/57*

24a. BURIAL CREMA-	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)

DISPOSITION TION, REMOVAL (Specify) BUREAU	END DATE Mch 7 th 1950	DISPOSITION OF REMOVED OR EXCLUDED OAKLAND	NUMBER NUMBER TWO
--	--------------------------------------	---	----------------------

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
--------------------------	-----------------------	----------------------------------	---------

3-7-50 ^{REG.} Leah Williams Lowe Mahan and Son Probate

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

MAR 13 1950

District Health Officer No. 10

3-30-43

District File Number

MAR 13 1950

Also 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

Frank D. D. West

Signed _____
Student Embalmer

Licensed Embalmer No. *3021*

P. O. Address

Woburn, Mass

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.