

FILED MAR 22 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11736

State File No.

BIRTH NO. _____ REG. DIST. NO. 360 PRIMARY REG. DIST. NO. 6225 Registrar's No. 30

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Bates</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Rural-Washington</u>	c. LENGTH OF STAY (In this place) <u>3 M. 7 D.</u>	c. CITY (If outside corporate limits, write RURAL and give township) <u>Butler Mo. rural!</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION. <u>State Hospital # 3</u>		d. STREET ADDRESS (If rural, give location) <u>Rural R. # 1</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Arnold</u> b. (Middle) <u>WMSTA</u> c. (Last) <u>TTD Umstatted</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>3 14 1950</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>4-3-1919</u>
9. AGE (In years last birthday) <u>30</u>		10. USUAL OCCUPATION (Give kind of work done at most of working life, even if retired) <u>laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>
11. BIRTHPLACE (State or foreign country) <u>Bates County Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>UMSTATTED Arthur Umstatted</u>		13b. MOTHER'S MAIDEN NAME <u>Ethel Green</u>	
14. NAME OF HUSBAND OR WIFE <u>none</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>	
16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs R.E. Sears Butler Mo R. 1.</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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary heart attack</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Dementia Praecox</u> <u>chronical condition</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION <u>-</u>	
19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DATE OF OPERATION <u>none</u>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>no</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u>	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>-</u>		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>-</u>	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>-</u>	
22. I hereby certify that I attended the deceased from <u>12-7-</u> , <u>1949</u> , to <u>3-14</u> , <u>1950</u> , that I last saw the deceased alive on <u>3-14</u> , <u>1950</u> , and that death occurred at <u>3:35 P.M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>J. Burch M.D.</u> (Degree or title)		23b. ADDRESS <u>State Hospital # 3</u>	
23c. DATE SIGNED <u>3-14-50</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
24b. DATE <u>3-16-50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Johnstown Cemetery</u>	
24d. LOCATION (City, town, or county) (State) <u>Johnstown Mo.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Calver-Underwood</u>	
DATE REC'D BY LOCAL REG. <u>Mar. 16, 1950</u>		REGISTRAR'S SIGNATURE <u>Kathryn H. Yaucy</u>	
25. ADDRESS <u>Butler Mo.</u>		25. ADDRESS <u>Butler Mo.</u>	

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

1080
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RECEIVED
District Health Officer No. 7,
District File Number 2-50-25
Date Filed 3-21-50

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 Wm. T. Hill

Licensed Embalmer No. 4743

P. O. Address Butler, 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.