

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED JAN 15 1951

BIRTH NO. _____ REG. DIST. NO. 187 PRIMARY REG. DIST. NO. 5699 Registrar's No. 206

1. PLACE OF DEATH a. COUNTY <u>Livingston</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Chariton</u> <u>0210</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Rural</u> <u>Chariton</u> <u>Livingston</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Mendon</u>	
c. LENGTH OF STAY (In this place) <u>10 days</u>		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Amalton Mrs.</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Katharine</u>	b. (Middle) <u>Elizabeth</u>	c. (Last) <u>Arnold</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 26. 1950</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u> <u>2</u>	8. DATE OF BIRTH <u>Sept. 29. 1873</u>	9. AGE (In years last birthday) (Month) (Day) (Year) <u>77</u> <u>2</u> <u>27</u>	IF UNDER 14 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>	11. BIRTHPLACE (State or foreign country) <u>Maquoketa Iowa</u> <u>1</u>	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME <u>James Anderson</u>	13b. MOTHER'S MAIEN NAME <u>Christie Bricker</u>	14. NAME OF HUSBAND OR WIFE <u>Albert Arnold</u>
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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>C. C. Lyons Mendon</u>	ADDRESS <u>Mo.</u>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>10 yrs</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arterio sclerosis</u> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>331X</u>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Dec 26, 1950, to Dec 26, 1950, that I last saw the deceased alive on Dec 26, 1950 and that death occurred at 10:00 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>G. W. Carpenter M.D.</u>	(Degree or title)	23b. ADDRESS <u>Chariton, Mo.</u>	23c. DATE SIGNED <u>Dec 29, 1950</u>
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24a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Dec. 29. 1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Hale Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Near Hale Missouri</u>
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DATE REC'D BY LOCAL REG. <u>Dec 29/50</u>	REGISTRAR'S SIGNATURE <u>Francis B. Neill</u>	25. GENERAL DIRECTOR'S SIGNATURE <u>Frank E. Slater</u>	ADDRESS <u>Hale Mo</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD



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 *Frank E. Slater*

Licensed Embalmer No. *937*

P. O. Address *Hals 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.