No. 300
10-48

FILED MAR 3 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7145

BIRTH NO. _____ REG. DIST. NO. 374 PRIMARY REG. DIST. NO. 6287 Registrar's No. _____

1. PLACE OF DEATH
a. COUNTY Wright
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Cedar Gap
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri b. COUNTY Wright
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Cedar Gap Rt 2
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Julian b. (Middle) c. (Last) Arbuckle

4. DATE OF DEATH (Month) Feb (Day) 21 (Year) 1952

5. SEX Male 6. COLOR OR RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M 8. DATE OF BIRTH Nov 10, 1867 9. AGE (If over 1 year last birthday) 84 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

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

13a. FATHER'S NAME Robert A. Arbuckle 13b. MOTHER'S MAIDEN NAME Unknown 14. NAME OF HUSBAND OR WIFE

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 ADDRESS Mrs Tom Morton Cedar Gap

MEDICAL CERTIFICATION

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.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Influenza
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 19b. MAJOR FINDINGS OF OPERATION 480X 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) m. 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 2-4, 19__, to Feb 24, 1952 that I last saw the deceased alive on _____, 19__, and that death occurred at 6:00 P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) C. Y. Beers M.D. 23b. ADDRESS Seymour Mo 23c. DATE SIGNED 2-22-52

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 24b. DATE 2/23/52 24c. NAME OF CEMETERY OR CREMATORY Mt Pleasant 24d. LOCATION (City, town, or county) (State) West of Willard Mo

DATE REC'D BY LOCAL REG. 2/23/52 REGISTRAR'S SIGNATURE [signature] 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. W. Klingner & Son Springfield

(Licensed Embalmer's Statement on Reverse Side)

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

WRIGHT CO. HEALTH DEPT.
County File Number 332-27
Date Filed May 1952

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 Alan L. Ferrell

Licensed Embalmer No. 4847

P. O. Address Mansfield, 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.