

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28484

State File No.

4229

No. 300
10-48

FILED SEP 15 1953

BIRTH NO. REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
d. FULL NAME OF HOSPITAL OR INSTITUTION 222I Forest Ave		d. STREET ADDRESS (If rural, give location) 222I Forest Ave	

3. NAME OF DECEASED (Type or Print) a. (First) Robert - b. (Middle) Ellen c. (Last) Arnold			4. DATE OF DEATH (Month) (Day) (Year) Aug- 27 1953		
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5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single		8. DATE OF BIRTH March-1st. 1900		9. AGE (In years last birthday) 53		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registrar High School Book store		11. BIRTHPLACE (City and State or Foreign Country) Woodlawn, Mo		12. CITIZEN OF WHAT COUNTRY? U.S.A	
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13a. FATHER'S NAME Samuel Arnold			13b. MOTHER'S MAIDEN NAME Emma Buckner			14. NAME OF HUSBAND OR WIFE Single		
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Lovena Kemp		ADDRESS 222I Forest Ave	
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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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Atherosclerosis ANTECEDENT CAUSES DUE TO (b) Hypertension Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH 4201	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)		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 **8/26**, 19**53**, to **8-27**, 19**53**, that I last saw the deceased alive on **8/26**, 19**53**, and that death occurred at **5:35A** m., from the causes and on the date stated above.

23a. SIGNATURE M. M. Halley (Degree or title) MD		23b. ADDRESS R.U. Med Center		23c. DATE SIGNED 8/28/53	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Aug, 31-53		24c. NAME OF CEMETERY OR CREMATORY Lincoln Cemetery		24d. LOCATION (City, town, or county) (State) Kansas City, Mo.	
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DATE REC'D BY LOCAL REG. 8-29-53		REGISTRAR'S SIGNATURE Shelding Smith		FUNERAL DIRECTOR'S SIGNATURE West Appleton Jones		ADDRESS K. C. 700	
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(Licensed Embalmer's Statement on Reverse Side)

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

Mr. Hiller

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 _____

E. H. West

Licensed Embalmer No. 2710

P. O. Address K. E. M. O.

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.