

FILED JUN 3 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15722
State File No. 2230
Registrar's No.

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

| | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Jackson</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Jackson</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u> | | c. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u> | |
| c. LENGTH OF STAY (in this place) <u>60 days</u> | | d. STREET ADDRESS (If rural, give location) <u>409 E 3rd</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Research Hosp</u> | | 2028 | |
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Wm</u> b. (Middle) <u>H.</u> c. (Last) <u>Arnold</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>5-16-54</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>1-18-1889</u> |
| 9. AGE (In years last birthday) <u>65</u> | IF UNDER 1 YEAR Months | IF UNDER 12 HRS. Days | IF UNDER 24 HRS. Hours |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Restaurant Owner</u> | | 11. BIRTHPLACE (State or foreign country) <u>Stittsburg Kansas Mo.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | 13. MOTHER'S MAIDEN NAME <u>Cora A. Bowman</u> | |
| 13a. FATHER'S NAME <u>Elige Arnold</u> | | 14. NAME OF HUSBAND OR WIFE <u>Rose Arnold</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes World War I</u> | | 16. SOCIAL SECURITY NO. <u>-</u> | |
| 17. INFORMANT'S SIGNATURE OR NAME <u>Rose Arnold</u> | | ADDRESS <u>409 E 3rd</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, asthma, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bilateral Broncho-Pneumonia</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Post-Op. Cardio. Rnd Failure</u> DUE TO (c) <u>Carcinoma of Colon</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>153X</u> | |
| 19a. DATE OF OPERATION <u>4/27/54</u> | | 19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of left colon</u> | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) | |
| 21b. PLACE OF INJURY (a. 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) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>4-25, 1954</u> , to <u>5-16, 1954</u> , that I last saw the deceased alive on <u>MAY 16, 1954</u> , and that death occurred at <u>1:45 P.M.</u> , from the causes and on the date stated above. | | | |
| 23a. SIGNATURE <u>E. H. Wilkinson, M.D.</u> | | 23b. ADDRESS <u>1332 Professional Bldg.</u> | |
| 23c. DATE SIGNED <u>5/18/54</u> | | 23d. LOCATION (City, town, or county) (State) | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> | | 24b. DATE <u>5-19-54</u> | |
| 24c. NAME OF CEMETERY OR CREMATORY <u>H. W. Camp</u> | | 24d. LOCATION (City, town, or county) (State) <u>1622 No</u> | |
| DATE REC'D BY LOCAL REG. <u>5-18-54</u> | | REGISTRAR'S SIGNATURE <u>Geraldine Smith</u> | |
| EMERALD DIRECTOR'S SIGNATURE <u>Paul J. Coetzee</u> | | ADDRESS <u>K-C-no.</u> | |

(Licensed Embalmer's Statement on Reverse Side)

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

Dr. W. Wilson

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.....

John B. Argentina

Licensed Embalmer No. *4773*

P. O. Address *K C No*

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.