

Health, Welfare and Public Service
 3000
 -56
 1-2070
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

FILED DEC 27 1956

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

44523
 STATE FILE NUMBER

Registration District No. 355 Primary Registration District No. 6205 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>Howell TEXAS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Specify before admission) a. STATE <u>Missouri</u> b. COUNTY <u>TEXAS Howell</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Pierce TWP</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Willow Springs, Mo</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			Length of stay in lb		d. STREET ADDRESS <u>Pierce TWP</u>		(If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle _____ Last <u>ARLEDGE</u>				4. DATE OF DEATH <u>Dec. 15, 1956</u> Month _____ Day _____ Year _____					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 25, 1906</u>		9. AGE (In years last birthday) <u>50</u> IF UNDER 1 YEAR: Months <u>8</u> Days <u>2</u> Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>construction</u>		11. BIRTHPLACE (City and state or country) <u>Catoosa, Oklahoma</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>John A. Arledge</u>				14. MOTHER'S MAIDEN NAME <u>Nellie Bobbitt</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no none</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Opal Arledge Willow Springs, Mo</u>			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GLIOMASARCOMA</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ <u>193X</u>							INTERVAL BETWEEN ONSET AND DEATH <u>NINE YEARS</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <u>Jan 5 '3</u> to <u>12/15/56</u> and last saw <u>him</u> alive on <u>12/15/56</u> Death occurred at <u>3:30 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>W. J. Terhune, M.D.</u> (Degree or title)				22b. ADDRESS <u>Willow Springs, Mo.</u>			22c. DATE SIGNED <u>12/16/56</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>12/18/56</u>		23c. NAME OF CEMETERY OR CREMATORY <u>City Cemetery</u>		23d. LOCATION (City, town, of county) (State) <u>Willow Springs, Mo.</u>			
24. FUNERAL DIRECTOR <u>Burns Willow Springs, Mo.</u>				ADDRESS		25. DATE RECD. BY LOCAL REG. <u>12-21-56</u>		26. REGISTRAR'S SIGNATURE <u>Anna Roberts</u>	

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em-
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Fred W. Barnes*.....

Licensed Embalmer No. *461*

P. O. Address *Willow Spru*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.