

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-028392  
STATE FILE NUMBER

FILED AUG 22 1958 Registration District No. 43 Primary Registration District No. 5135 Registrar's No. 495

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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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>BUTLER</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>BUTLER</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ASHHILL</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>RURAL</b>		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 1b <b>2 YRS.</b>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>MADISON</b> Last <b>ARNOLD</b>			4. DATE OF DEATH Month <b>7</b> - Day <b>8</b> - Year <b>1958</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-31-1895</b>	9. AGE (In years) <b>62</b>	IF UNDER 1 YEAR Month <b>10</b> Days <b>05</b>
10a. USUAL OCCUPATION (Give kind of work done) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	11. BIRTHPLACE (City and state or country) <b>Tennessee</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Robert Lewis Arnold</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Cleora Arnold</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, (Unknown)) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>491267099</b>		17. INFORMANT Address <b>Cleora Arnold, Fisk, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocarditis</b> DUE TO (b) <b>Arteriosclerosis</b> DUE TO (c) <b>4221</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Epilepsy about 2 yrs ago</b>					INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b> <b>10 yrs.</b>
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 <b>June 1956</b> to <b>8 July 58</b> and last saw him alive on <b>5 July 58</b> Death occurred at <b>7 AM</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Cynthia C. Vest M.D.</b>			22b. ADDRESS <b>Poplar Bluff, Mo</b>		22c. DATE SIGNED <b>7 July 58</b>
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>7-10-58</b>	23c. NAME OF CEMETERY OR CREMATOR <b>Brown Chapel</b>		23d. LOCATION (City, town, or county) (State) <b>Butler Co. Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>J. C. White Fisk, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>8/16/58</b>	26. REGISTRAR'S SIGNATURE <b>R. Frumetree</b>	

RECEIVED

AUG 19 1958

BUTLER CO. HEALTH CENTER

FILE No. \_\_\_\_\_

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 \_\_\_\_\_  
Signature of Student Embalmer

Signed *Raymond L. Duffie*  
Licensed Embalmer No. *4798*  
P. O. Address *Bernie, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.