

FILED VS. OCT 16 1959

Registration District No. 353 Primary Registration District No. 3874 Registrar's No. 172

STATE FILE NUMBER

RECEIVED

1. PLACE OF DEATH a. COUNTY <u>SCOTT</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>SCOTT</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>RURAL</u>		Length of stay in 1b		c. CITY OR TOWN <u>CHAFFEE</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>BENTON P.F.D.</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>209 N. 3RD ST</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last <u>HOWARD WILLIAM ARNOLD</u>				4. DATE OF DEATH Month Day Year <u>10-1-1959</u>									
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>10-8-1907</u>		9. AGE (last birthday) <u>51</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) <u>RET.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>GEN. MOTOR CORP.</u>			11. BIRTHPLACE (City and state or country) <u>STODDARD Co. Mo</u>			12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>				
13a. FATHER'S NAME <u>EDWARD ARNOLD</u>				13b. MOTHER'S MAIDEN NAME <u>DELLA COKLEY</u>				14. NAME OF HUSBAND OR WIFE <u>Dora</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>376125087</u>		17. INFORMANT <u>Mr. Dora Arnold - Chaffee 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>GUN SHOT WOUND RIGHT SIDE OF HEAD.</u>										INTERVAL BETWEEN ONSET AND DEATH <u>0</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" 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 <u>APP. 10:45</u> Hour p.m.		Month, Day, Year <u>10-1-59</u>											
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>COUNTRY ROAD -</u>			20f. CITY, TOWN, OR LOCATION <u>R.F.D. BENTON</u>		COUNTY <u>SCOTT</u>		STATE <u>Mo.</u>				
21. I attended the deceased from <u>FIRST CALL AFTER DEATH</u> and last saw her/him alive on <u>APP. 10:45 P.</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>[Signature]</u> (Deceased or title)				22b. ADDRESS <u>Sikeston Mo.</u>				22c. DATE SIGNED <u>10/3/59</u> (State)					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>10-2-59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CRESTWOOD</u>			23d. LOCATION (City, town, or county) <u>FLINT MICH</u>						
24. FUNERAL DIRECTOR <u>Welch Funeral Home - Sikeston Mo</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>10-6-59</u>		26. REGISTRAR'S SIGNATURE <u>Max Ellen Hunter</u>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

007-20

**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 Crews

Licensed Embalmer No. 3467

P. O. Address Sikeston 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.