MO DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS MAR 2 S 1960

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 48

60-010728 STATE FILE NUMBER

DED

1. PLACE OF DEATH
a. COUNTY Howell
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN West Plains
Length of stay in 1b: 11 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION West Plains Mem. Hosp. Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Howell
c. CITY OR TOWN West Plains Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 410 Summit Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First Reason Middle F. Last Arrington

4. DATE OF DEATH: Month, Day, Year: March 20, 1960

5. SEX: Male

6. COLOR OR RACE: White

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 8-6-1869

9. AGE (last birthday): 90

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HR: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (City and state or country): Cabot, Arkansas

12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: William Arrington

13b. MOTHER'S MAIDEN NAME: Sarah Tolbert

14. NAME OF HUSBAND OR WIFE: Susie P. Arrington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None

16. SOCIAL SECURITY NO.

17. INFORMANT Address: Susie P. Arrington, West Plains, Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio Vascular Renal Disease
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Senility
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 7 Mar 1960, to 20-3-60 and last saw ~~him~~ alive on 20-3-60
Death occurred at 1500 hours m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) MD

22b. ADDRESS West Plains, Mo

22c. DATE SIGNED 21/3/60

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 3-22-1960

23c. NAME OF CEMETERY OR CREMATORY: ?

23d. LOCATION (City, town, or county) (State): Memphis, Tennessee

24. FUNERAL DIRECTOR ADDRESS: Gilmore Carter, West Plains, Mo

25. DATE RECD. BY LOCAL REG.: 3-22-60

26. REGISTRAR'S SIGNATURE: Beatrice Cook

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Leland Carter

Licensed Embalmer No. 4516

P. O. Address [illegible]

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co
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.