

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

4565-61-032717
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4565

FILED SEP 25 1961

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, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		c. CITY OR TOWN <u>KANSAS CITY</u>	
Length of stay in 1b <u>11 YEARS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>632 HARDESTY</u>		d. STREET ADDRESS (If outside, give location) <u>632 HARDESTY</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>FANNIE</u> <u>ARNOLD</u>			4. DATE OF DEATH Month Day Year <u>SEPT 6 1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-29-1877</u>	9. AGE (last birthday) <u>84</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (City and state or country) <u>CHERRYVALE KANS</u>		12. CITIZEN OF WHAT COUNTRY <u>USA.</u>
13a. FATHER'S NAME <u>LOUIE GEARY</u>		13b. MOTHER'S MAIDEN NAME <u>MARY JANE BALES</u>		14. NAME OF HUSBAND OR WIFE <u>CHASE ARNOLD</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>NONE</u>		17. INFORMANT <u>MRS GLENN DAVIS</u> Address <u>KANSAS CITY MO</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Adenocarcinomatosis</u>		<u>1 YR</u>
DUE TO (b) <u>Adenocarcinoma Rectum</u>		<u>4 Yr.</u>
DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Fracture Lt hip 1 mo</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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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 _____ a.m. _____ p.m. Month, Day, Year _____	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 June 1957 to Aug 1961 and last saw her/him alive on 8/24/61
Death occurred at 1:00 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>John S. Campbell</u> (Degree or title) <u>M.D.</u>		22b. ADDRESS <u>224 Prof. Bldg K.C. MO</u>		22c. DATE SIGNED <u>9-11-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>9-6-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>KNOBNOSTER CEM.</u>	
23d. FUNERAL DIRECTOR <u>CANADAY & FROST HOLDEN MO</u>		23d. LOCATION (City, town, or county) <u>KNOBNOSTER MO</u>		(State)
24. ADDRESS		25. DATE RECD. BY LOCAL REG. <u>9-13-61</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Song</u>	

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF John S. Campbell
 SHOULD READ
 ITEM 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 M J Canada

Licensed Embalmer No. 34341

P. O. Address Holden

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.