

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-038023

STATE FILE NUMBER

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

FILED OCT 26 1961

1. PLACE OF DEATH

a. COUNTY

PIKE

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR
TOWN LOUISIANALength of stay in 1b
15 HRS.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Mo.

b. COUNTY

PIKE

c. CITY
OR
TOWN

FRANKFORD

Inside Limits
Yes ☒ No ☐c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR
INSTITUTION

PIKE CO. HOSPITAL

Inside Limits
Yes ☒ No ☐d. STREET
ADDRESS

(If outside, give location)

Reside on Farm
Yes ☐ No ☐3. NAME OF DECEASED
(Type or print)

First

Middle

Last

WILLIAM

LLOYD

ARNOLD

4. DATE
OF
DEATH

Month

Day

Year

OCT

21

1961

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. Married ☒ Never Married ☐Widowed ☐ Divorced ☐

8. DATE OF BIRTH

SEPT 20 1891

9. AGE (last birthday)

70

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)
CARPENTER - PAINTER

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)

PATTERSON ILL.

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

WILLIAM ARNOLD

13b. MOTHER'S MAIDEN NAME

SYLVIA NEECE

14. NAME OF HUSBAND OR WIFE

RUTH ARNOLD

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

488-20-0901

17. INFORMANT

Address

MRS. RUTH ARNOLD FRANKFORD Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Ruptured Aortic Aneurysm

INTERVAL BETWEEN
ONSET AND DEATHConditions, if any,
which gave rise to
above cause (a),
stating the under-
lying 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.☐ Yes ☐ No ☐ Unknown19. 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

Month, Day, Year

a.m.

p.m.

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 10-20-61 to 10-21-61 and last saw him alive on 10-21-61
Death occurred at 10:45 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

E. P. Hansen D.D.

22b. ADDRESS

Frankford Mo. 10-23-61

22c. DATE SIGNED

23a. BURIAL, CREMATION,
REMOVAL (Specify)

BURIAL

23b. DATE

OCT 24 1961

23c. NAME OF CEMETERY OR CREMATORY

MOUNT AIR CEMETERY

23d. LOCATION (City, town, or county)

CURRYVILLE Mo.

(State)

RURAL

24. FUNERAL DIRECTOR

ADDRESS

MEGOWN FUNERAL HOME FRANKFORD Mo

25. DATE RECD. BY LOCAL REG.

OCT 23 - 61

26. REGISTRAR'S SIGNATURE

Bernice Collier

(Licensed Embalmer's Statement on Reverse Side)

1961 6 AON

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 Lone Fields Meyerson

Licensed Embalmer No. 4093

P. O. Address Frankford 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.