

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**=62-030291**

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 59 Primary Registration District No. \_\_\_\_\_ Registrar's No. 132

**FILED SEP 4 1962**

1. PLACE OF DEATH a. COUNTY <u>Cass</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cass</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Harrisonville</u>		c. CITY OR TOWN <u>Pleasant Hill (rural)</u>	
Length of stay in 1b <u>2 da.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>R.F.D. 2 Polk Twp.</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Tammie</u> Middle <u>Jolene</u> Last <u>Arnold</u>			4. DATE OF DEATH Month <u>August</u> Day <u>21</u> Year <u>1962</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8/20/62</u>	9. AGE (last birthday) <u>0</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Harrisonville, Mo.</u>	
				12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	

13a. FATHER'S NAME <u>James F. Arnold</u>		13b. MOTHER'S MAIDEN NAME <u>Jo Ann Schaal</u>		14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>James F. Arnold</u> Address <u>Pleasant Hill, Mo.</u>	

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>Prematurity at 30 1/2 wks</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <u>after conception</u> DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u>
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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	
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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 <u>Pleasant Hill, Mo</u>	COUNTY _____ STATE _____
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21. I attended the deceased from 8-20-62 to 8-21-62 and last saw her alive on 11 45 PM 8-21-62  
Death occurred at 11 45 PM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Ch W Eklund MD</u> (Degree or title)	22b. ADDRESS <u>Pleasant Hill, Mo</u>	22c. DATE SIGNED <u>8-21-62</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>8/23/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Strasburg Cem.</u>	23d. LOCATION (City, town, or county) <u>Strasburg, Missouri</u>
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24. FUNERAL DIRECTOR <u>Brownfield-Stanley</u> ADDRESS <u>Pleasant Hill, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>8/28/62</u>	26. REGISTRAR'S SIGNATURE <u>Ray &amp; Lebrue</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300  
Rev. 4/59

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**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 A. Stanley

Licensed Embalmer No. 5008

P. O. Address Pleasant Hill, 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.