

- MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-033881

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 1026
FILED OCT 9 1962

VS 300
Rev. 4/59

1: 0128
2: 0128
3:
4: 0
5: 1
6:
7: 1
8: 2
9392X
10:
11:
12: 5-0
13: 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY BUTLER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY BUTLER	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN POPLAR BLUFF		Length of stay in 1b 68 DAYS	c. CITY OR TOWN POPLAR BLUFF Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 803 E. DAVIS Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last JAMES FRANKLIN ARNOLD			4. DATE OF DEATH Month Day Year SEPTEMBER 13 1962
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-8-92
9. AGE (last birthday) 69		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) MINISTER		10b. KIND OF BUSINESS OR INDUSTRY MINISTERIAL	11. BIRTHPLACE (City and state or country) CRAIGHEAD COUNTY ARK.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME JAMES T. ARNOLD	
13b. MOTHER'S MAIDEN NAME ARMETTA J. SHUTLEY		14. NAME OF HUSBAND OR WIFE WILLIE ARNOLD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WWI		16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT Address VA HOSPITAL RECORDS, POPLAR BLUFF, 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) CEREBRAL THROMBOSIS		INTERVAL BETWEEN ONSET AND DEATH 7 MONTHS	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) CEREBRAL ARTERIOSCLEROSIS		gwb	
DUE TO (c) _____		gwb.	
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 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. Attended the deceased from JULY 7, 1962 to SEPTEMBER 13, 1962 Death occurred at 6:25 P m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Robert S. Cohen (Degree) ROBERT S. COHEN, M.D. Chief Medical Ser.		22b. ADDRESS VA HOSPITAL, POPLAR BLUFF, MO.	22c. DATE SIGNED 9-24-62
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9-15-1962	23c. NAME OF CEMETERY OR CREMATORY City Cemetery	23d. LOCATION (City, town, or county) Poplar Bluff, Mo.
24. FUNERAL DIRECTOR Greer Croy & Fitch Poplar Bluff, Mo.		25. DATE RECD. BY LOCAL REG. 10-5-1962	26. REGISTRAR'S SIGNATURE Helma Graham

USE BLACK INK OR TYPEWRITER RIBBON

7961 OT 130

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 Philip J. Cassery

Licensed Embalmer No. 4618

P. O. Address Poplar Bluff, 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.