

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-047580

STATE FILE NUMBER

Registration District No. 179 Primary Registration District No. 4287 Registrar's No. 169

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 2 1962	
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>LINCOLN</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Troy</u> Length of stay in 1b <u>6 Yrs.</u></p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Sunset Home</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>Missouri</u> COUNTY <u>LINCOLN</u></p> <p>c. CITY OR TOWN <u>Troy</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <u>451 W. Cherry St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>
<p>3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>ARNER</u> Last <u>ARNER</u></p>	
<p>4. DATE OF DEATH Month <u>Dec.</u> Day <u>24</u> Year <u>1962</u></p>	
<p>5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> 8. DATE OF BIRTH <u>6/6/90</u> 9. AGE (last birthday) <u>72</u></p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> 11. BIRTHPLACE (City and state or country) <u>Conn.</u> 12. CITIZEN OF WHAT COUNTRY <u>USA</u></p>	
<p>13a. FATHER'S NAME <u>Samuel Arner</u> 13b. MOTHER'S MAIDEN NAME <u>Katherine (Unk)</u> 14. NAME OF HUSBAND OR WIFE <u>Celeste</u></p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <u>Yes WWI</u> 17. INFORMANT Address <u>Troy, Mo. Celeste Arner, 451 W. Cherry</u></p>	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:</p> <p style="text-align: center;">IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> INTERVAL BETWEEN ONSET AND DEATH <u>72 HOURS</u></p> <p style="text-align: center;">DUE TO (b) <u>CEREBRAL ARTERIOSCLEROSIS</u> <u>UNK</u></p> <p style="text-align: center;">DUE TO (c) _____</p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____</p> <p>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</p>	
<p>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.) _____</p>	
<p>20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____</p>	
<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 20e. PLACE OF INJURY (e.g., in-pr about home, farm, factory, street, office bldg., etc.) _____ 20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____</p>	
<p>21. I attended the deceased from <u>1958</u> to <u>12/24/62</u> and last saw him <u>her</u> alive on <u>DEC. 24, 1962</u>. Death occurred at <u>3:30 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.</p>	
<p>22a. SIGNATURE (Degree or title) <u>Paul T. Berry MD</u> 22b. ADDRESS <u>Troy, Mo.</u> 22c. DATE SIGNED <u>12/28/62</u></p>	
<p>23a. BURIAL, CREMATION, REMOVAL <u>Removal</u> 23b. DATE <u>12/27/62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Linville</u> 23d. LOCATION (City, town, or county) (State) <u>Coldwater, Mo.</u></p>	
<p>24. FUNERAL DIRECTOR ADDRESS <u>McLaughlin, 2301 Lafayette, St. Louis, Mo.</u> 25. DATE RECD. BY LOCAL REG. <u>12-28-1962</u> 26. REGISTRAR'S SIGNATURE <u>Charlotte Seek</u></p>	

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

PERMIT ISSUED DEC. 24, 62

JAN 7 1963

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

James R. Chapman

Licensed Embalmer No. 4550

P. O. Address St. Louis, 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.