

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-032568

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 157 Primary Registration District No. 3028 Registrar's No. 159 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED AUG 26 1963

VS 300
Rev. 4/59

1 0497

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>JASPER</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>JASPER</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CARTHAGE</u>		c. CITY OR TOWN <u>CARTHAGE</u>	
Length of stay in 1b <u>1 WEEK</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>923 S. ORNER ST.</u>		d. STREET ADDRESS (If outside, give location) <u>ROUTE 4</u>	
3. NAME OF DECEASED (Type or print) First <u>NEWTON</u> Middle <u>THOMAS</u> Last <u>ARNOLD</u>		4. DATE OF DEATH Month <u>AUGUST</u> Day <u>7</u> Year <u>1963</u>	
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>4/27/81</u>
9. AGE (last birthday) <u>82</u>		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) <u>FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AGRICULTURE</u>	11. BIRTHPLACE (City and state or country) <u>DALLAS CO., MO.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>SAMUEL B. ARNOLD</u>	
13b. MOTHER'S MAIDEN NAME <u>ELIZA PATTERSON</u>		14. NAME OF HUSBAND OR WIFE <u>DELIA HIGHFILL ARNOLD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <u>NO</u>		16. SOCIAL SECURITY NO. <u>36</u>	
17. INFORMANT <u>MRS. DELIA H. ARNOLD, CARTHAGE, MO.</u>		Address _____	
18. CAUSE OF DEATH (Enter only one cause per time for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage from stomach</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
DUE TO (b): <u>Gastric ulcer</u>			<u>3 yrs</u>
DUE TO (c): _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease/condition given in PART I (e) <u>Arteriosclerosis, generalized & left hemiplegia</u>			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. I attended the deceased from <u>3-7-53</u> to <u>8-7-63</u> and last saw him alive on <u>8-6-63</u> Death occurred at <u>6:08 P.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>M. Foster Blutter</u> M.D.		22b. ADDRESS (MO.) <u>616 W. CENTENNIAL, CARTHAGE</u>	
22c. DATE SIGNED <u>8-9-63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>8/10/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>PARK CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>CARTHAGE, MISSOURI</u>
24. FUNERAL DIRECTOR ADDRESS <u>ULMER FUNERAL HOME, CARTHAGE, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>8-9-63</u>	26. REGISTRAR'S SIGNATURE <u>Ely Blutter</u>

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

Melvin Garrett

Licensed Embalmer No. 5121

P. O. Address CARTHAGE, 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.