WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important

MAY 22 1933

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

13810

1 PLACE OF DEATH

County Linn

Township North Salem
or
Village
or
City (NO. , St.; Ward)

Registration District No. 497 File No.

Primary Registration District No. 5672 Registered No. 27

[If death occurred in hospital or institution give its NAME instead of street and number.]

2 FULL NAME Micheal Elmer Arnold

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married ~~Widowed~~

6 DATE OF BIRTH: Aug (Month) 2 (Day) 1867 (Year)

7 AGE: 65 yrs. 7 mos. 29 ds. If LESS than 1 day, ...hrs. or ....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (City or town, State or foreign country): Mo.

PARENTS

10 NAME OF FATHER: Simon Arnold

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): West Virginia

12 MAIDEN NAME OF MOTHER: Mary Wolf

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): West Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Anna Arnold
(Address) North Salem, Mo

15 Filed 5/1 1933 (Mrs) Elsie Alspach Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Apr 1st (Month) (Day) 1933 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan. 3rd 1932, to Jan 31st 1933, that I last saw him alive on Jan. 33st 1933, and that death occurred, on the date stated above, at 3-30 P.m.

The CAUSE OF DEATH* was as follows:
Round cell sarcoma

(Duration) 1 yrs. 2 mos. 27 ds.

CONTRIBUTORY (Secondary)
x (Duration) x yrs. x mos. x ds.

(Signed) J. M. Boyles M. D.
4-2 1933 (Address) Purdin Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.
Where was disease contracted if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: North Salem, Mo. DATE OF BURIAL: Apr 3 1933

20 UNDERTAKER: Glenn E Kent ADDRESS: Green City, Mo

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*) For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum* etc., *Carcinoma*, *Sarcoma*, etc., of [illegible] definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death) [illegible] *29 ds.; Bronchopneumonia* (secondary), [illegible] report mere symptoms or terminal cond [illegible] "*Asthenia*," "Anaemia" (merely symptoma [illegible] "Collapse," "Coma," "Convulsions," "D [illegible] genital," "Senile," etc.), "Dropsy," "Exha [illegible] failure," "Haemorrhage," "Inanition," "M [illegible] age," "Shock," "Uraemia," "Weakness," [illegible] definite disease can be ascertained as the [illegible] qualify all diseases resulting from chil [illegible] carriage, as "PUERPERAL *septichaemia*," [illegible] *peritonitis*," etc. State cause for which sur [illegible] was undertaken. For VIOLENT DEATHS st [illegible] INJURY and qualify as ACCIDENTAL, SUICID [illegible] CIDAL, or as *probably* such, if impossible [illegible] definitely. Examples: *Accidental drownin* [illegible] *railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Linn — Registration District No. 497 — File No.

Township N Salem — Primary Registration District No. 5672 — Registered No. 27

City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME Michael Elmer Arnold

(a) Residence, No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	W	M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE ..... DATE ....., 19....

19. UNDERTAKER (ADDRESS)

20. FILED June, 1933 (Mrs) Elsie Alspach, Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr. 1, 1933

22. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19....

I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at ..... m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Round cell - sarcoma	
45 C	

Other contributory causes of importance: Below Right Tonsil

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19.....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) ....., M. D.

(Address) .....

SUPPLEMENTARY

5-13810