

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.

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

5665  
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399  
 (b) Township Kaw Primary Registration District No. 1002  
 (c) City K.C. (d) Street No. 6414 Montgall Registered No. 864  
 (If death occurred in Hospital or Institution, write its name instead of street and number) St.  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Viola Elizabeth Arnold  
 (a) Residence, No. 6414 Montgall St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX ♀ 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF James C. Arnold  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 17 - 1900  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
38      4      9  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc. housewife  
 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) Marceline, Mo.

FATHER 13. NAME A. J. Smith

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

MOTHER 15. MAIDEN NAME Arzelia Wolfe

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

17. INFORMANT (ADDRESS) James C. Arnold  
6414 Montgall

18. BURIAL, CREMATION, OR REMOVAL PLACE Marceline DATE 2/27 19  
19

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Bentley Paul. Howe  
5811 Transit Ave.

20. FILED 7/27 1939 M. M. Crowe  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2/26/39 1939  
 22. I HEREBY CERTIFY, That I attended deceased from 2/26 39 to 2/26 39  
 I last saw her alive on 2/26 1939 Death is said to have occurred on the date stated above, at 9 pm m.  
 The principal cause of death and related causes of importance were as follows:

acute cardiac dilation  
terminal pulmonary congestion  
hypertension and renal congestion  
 Other contributory causes of importance:  
chronic extensive adhesive yrs.  
congestive chronic fibroid  
inflammation (tuberculosis?)

Name of operation..... Date of.....  
 What test confirmed diagnosis clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? no 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 just falling (Signed) 824 Wendell Berg M. D.  
 (Address)

J. W. Hallberg - M. D.  
Medical Arts Bldg.  
(Va 5150.)

James M. Laughlin  
Martinsburg, W. Va.

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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 .....

Registered Apprentice No. ...., working under my personal supervision.

Signed.....

Licensed Embalmer No. ....

P. O. Address.....

**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 this body is not embalmed, above space should be left blank.**