

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

FILED FEB 13 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3191

Registration District No. 409

Primary Registration District No. 4363

Registrar's No. 18

1. PLACE OF DEATH:
 (a) County Newton
 (b) City or town Neosho
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Sale-Bowman Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 day
 (Specify whether
 In this community _____
 years, months or days) 1 13

3. (a) PRINT FULL NAME Roy Daneen Arehart
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Aug. 9, 1939
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
5 11 _____ hr. _____ min.

9. Birthplace Newton County Mo.
 (City, town, or county) (State or foreign country)

10. Usual occupation Child

11. Industry or business _____
 12. Name Roy Arehart
 13. Birthplace McDonald County Mo.
 (City, town, or county) (State or foreign country)
 14. Maiden name Anna Lou Vangundy
 15. Birthplace Wyandotte, Okla.
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Roy Arehart
 (b) Address Seneca, Mo.

17. (a) Baptist cem. (b) Date thereof Jan. 21 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Near Seneca, Mo.

18. (a) Signature of funeral director Mitchell-Chase
 (b) Address Seneca, Mo.

19. (a) Jan 22 - 40 (b) Orval C. Sale, M.D.
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Newton
 (c) City or town Seneca
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 20
 year 1940 hour 8 minute 30 P. M.
 21. I hereby certify that I attended the deceased from Jan. 19
 _____, 19 40 to Jan. 20, 19 40
 that I last saw him alive on Jan. 20, 19 40
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
Streptococcic septicemia
 Due to Pneumonia
 Due to _____
 Other conditions None
 (Include pregnancy within 3 months of death)

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically

Major findings:
 Of operations None
 Of autopsy None

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) _____ (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place)
 23. Signature Orval C. Sale (M. D. or physician)
 Address Neosho, Mo. Date signed 1-22

RECEIVED

District Health Officer No. 6,

District File Number 240-444

Date Filed FEB 13 1940

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STATE HEALTH DEPARTMENT
DIVISION OF VITAL RECORDS
FEB 13 1940

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

3191
Do not use this space.

1. PLACE OF DEATH
 (a) County Newton Registration District No. 609
 (b) Township _____ Primary Registration District No. 43 63
 (c) City Neosho (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (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 Roy Deereen Archart
 (a) Residence, No. _____ St. _____
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) s

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.
5 11

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

FATHER
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
 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. FUNERAL DIRECTOR (ADDRESS) _____
 20. FILED 1-22 1940 Mal R. Sale Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-20 1940

22. I HEREBY CERTIFY, That I attended deceased from _____ 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:
Streptococcus Sep
titemia
Pneumonia (Bronchial)
 Other contributory causes of importance:
Streptococcus tonsillitis

Name of operation _____ Date of _____
 What test confirmed diagnosis? 115 N 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 Oral E. Sale M. D.
 (Signed) _____ (Address) Neosho Mo

SUPPLEMENT

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.

S-3191