

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 6312

FILED MAR 7 - 1940

Registration District No. 48

Primary Registration District No. 3011

Registrar's No. 28

1. PLACE OF DEATH:

(a) County Clay
 (b) City or town Excelsior Springs Mo.
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Excelsior Springs Hosp. 3
(If not in hospital or institution, write street number & location)
 (d) Length of stay: In hospital or institution 3 days
(Specify whether years, months or days)
 In this community 25 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clay
 (c) City or town Excelsior Springs
(If outside city or town limits, write "RURAL")
 (d) Street No. West St.
(If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME ORAS. ARROTT L. 30

3. (b) If veteran, name's war X 3. (c) Social Security No. X

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced, widowed
 6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive deceased years
 7. Birth date of deceased Sept. 23 1876
(Month) (Day) (Year)

8. AGE: Years 64 Months 4 Days 18 If less than one day hr. _____ min. _____

9. Birthplace New Haven Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Saundry

MOTHER FATHER
 11. Industry or business _____
 12. Name Geed Shelton (Hull)
 13. Birthplace New Haven Mo.
(City, town, or county) (State or foreign country)
 14. Maiden name unknown
 15. Birthplace unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Turner B. Long
 (b) Address Excelsior Springs Mo.
 17. (a) Crown Hill (b) Date thereof, Feb 13 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Crown Hill
 18. (a) Signature of funeral director, Herbert Hope
 (b) Address Excelsior Springs
 19. (a) Feb 13 1940 (b) Mrs Rae H. Cracker
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2/11/1940 day 11
 year 1940 hour One minute 35 A. M.

21. I hereby certify that I attended the deceased from Feb 8
1940 to Feb 11 1940
 that I last saw her alive on Feb 10 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Stroke apoplexy Duration 2 days
 Due to Hypertension
 Due to _____
 Other conditions Gastritis
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy _____
 Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following: no
 (a) Accident, suicide, or homicide (specify) 11
 (b) Date of occurrence none
 (c) Where did injury occur? none
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? none (Specify type of place)
 (e) Means of injury 180
 23. Signature H. J. Clark (M. D. or other) 1
 Address Excelsior Springs Mo. Date signed 2/13/40

RECEIVED
District Health Officer No. 8,
3/5/40

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 _____

Herbert Hope, Registered Apprentice No. _____
working under my personal supervision.

Signed Herbert Hope
Licensed Embalmer No. 3199
P. O. Address Excelsior Springs

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **6312**
Registrar's No. **28**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **198**

Primary Registration District No. **3011**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County **Clay**
(b) City or town **Excelsior Springs**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community..... (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Dora S. Arrott**
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **wid**
6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year
7. Birth date of deceased **9 23 1876**
(Month) (Day) (Year)

8. AGE: Years **63** Months **4** Days **18** If less than one day hr min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace..... (City, town, or county) (State or foreign country)

14. Maiden name..... (City, town, or county) (State or foreign country)

15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant..... (b) Address.....

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) **Feb 13, 1946** (b) **Mrs. R. W. Cracker**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State..... (b) County.....
(c) City or town..... (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.

19. MEDICAL CERTIFICATION
20. DATE OF DEATH Month **2** day **11**
year **1946** hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19.....
that I last saw h..... alive on..... 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

Due to.....

Due to.....

Other conditions..... (Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy.....

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) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature **H. J. Clarke** (M. D. or other).....
Address **Excelsior Springs**.....

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

SUPPLEMENTARY

