

MARGIN RESERVED FOR BINDING

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.

Registration District No. 831

Primary Registration District No. 4553

Registrar's No.

1. PLACE OF DEATH:

(a) County Scott  
(b) City or town Sikeston, Mo.  
(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 \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community 23 Years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County \_\_\_\_\_  
(c) City or town S  
(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.

8. (a) PRINT FULL NAME Charles Arbaugh 6/2  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month January Day 15 year 1940 hour 11:45 PM

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Lizzie Arbaugh 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Feb 20 1870  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from April 7 1939 to Jan 15 1940  
that I last saw him alive on January 15 1940  
and that death occurred on the date and hour stated above.

8. AGE: Years 69 Months 11 Days 25 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Coronary Sclerosis Duration 1-15-40  
Due to General Arteriosclerosis 1-1-39  
Due to \_\_\_\_\_

9. Birthplace Grayville Ill  
(City, town, or county) (State or foreign country)  
10. Usual occupation Farmer

Other conditions (Include pregnancy within 3 months of death) 94  
Major findings: Of operations none  
Of autopsy no

11. Industry or business \_\_\_\_\_  
12. Name Jessie Arbaugh  
13. Birthplace Va.  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

PHYSICIAN \_\_\_\_\_  
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) \_\_\_\_\_  
(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 \_\_\_\_\_

16. (a) Informant's own signature William Arbaugh  
(b) Address 408 E. Center  
17. (a) \_\_\_\_\_ (b) Date thereof Jan. 21 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery  
18. (a) Signature of funeral director J. D. Simpson  
(b) Address Dixton Mo  
19. (a) 2-7-40 (b) W. H. Orrell  
(Date received local registrar) (Registrar's signature)

23. Signature M. H. Anderson (M. D. or other) \_\_\_\_\_  
Address Sikeston Date signed 1-23-40

50M-5-17-39 Rev. 5-17-39 I 19381

RECEIVED

District Health Officer No. 2  
District File Number 240-631  
Date Filed 2/26/40

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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 Hunter Albritton

Licensed Embalmer No. 2940

P. O. Address Spokane 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 this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. **8298**

Registration District No. **881**

Primary Registration District No. **4533**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County **Scott**  
(b) City or town **Rexford**  
(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 \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME **Charles Arbanga**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **m**

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years **69** Months **11** Days **25** If less than one day \_\_\_\_\_ 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 \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

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

(b) Address \_\_\_\_\_

19. (a) **4-15-1940** (b) **[Signature]** (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH \_\_\_\_\_ month **Jan** day **15** year **1940** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ 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 **[Signature]** (M. D. or other) \_\_\_\_\_

Address **Rexford** Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

