DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

34465

State File No.

FILED NOV 12 1940

Registration District No. 1009

1002

Primary Registration District No.

Registrar's No. 3981

**1. PLACE OF DEATH:**

(a) County: Jackson

(b) City or town: Kansas city

(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Research Hospital

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 2 days (Specify whether years, months or days)

In this community: Non-Resident

**2. USUAL RESIDENCE OF DECEASED:**

(a) State: Missouri (b) County: Clay

(c) City or town: Liberty

(If outside city or town limits, write "RURAL")

(d) Street No.: 0

(If rural, give location)

(e) If foreign born, how long in U. S. A.? ✓ years.

3. (a) PRINT FULL NAME: Frances Smith Arnold

3. (b) If veteran, name war: no

3. (c) Social Security No.: no

4. Sex: Female

5. Color or race: White

6. (a) Single, widowed, married, divorced: married

6. (b) Name of husband or wife: H F Arnold

6. (c) Age of husband or wife if alive: 76 years

7. Birth date of deceased: June (Month) 13 (Day) 1867 (Year)

8. AGE: Years 73 Months 4 Days 4 If less than one day hr. min.

9. Birthplace: Mound Creek (City, town, or county) Tenn. (State or foreign country)

10. Usual occupation: Home wife

11. Industry or business:

FATHER 12. Name: James A. Smith

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

MOTHER 14. Maiden name: Martha Ellen Cox

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

16. (a) Informant's own signature: Mrs. Ethel Bamster

(b) Address: Liberty Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/19/40 (Month) (Day) (Year)

(c) Place: burial or cremation: Liberty Mo

18. (a) Signature of funeral director: Lynch-Archer Co.

(b) Address: Liberty, Mo.

19. (a) 10-17-40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Oct. day 17 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from Oct 15, 1940, to Oct 17, 1940 that I last saw he was alive on Oct 17, 1940; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Tetanus | 2 days |
| Due to: | |
| Due to: | |
| Other conditions (Include pregnancy within 3 months of death): | |
| Major findings: Of operations: | |
| Of autopsy: | |

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

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? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: Gustafson MD (M. D. or other)

Address: Liberty, Mo. Date signed 10/17

(Licensed Embalmer's Statement on Reverse Side)

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.

REV. 8-17-39 — 1 X 19311

## 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 Edgar Archer.

Licensed Embalmer No. 3211

P. O. Address Liberty, 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.**

S. No. 2B
—2-21-40
I X22659

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

NOV 12 1940

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# STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. Primary Registration District No. Registrar's No. 3981

**1. PLACE OF DEATH:**

(a) County

(b) City or town (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Research Hospital (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)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State (b) County

(c) City or town (If outside city or town limits write "RURAL")

(d) Street No. Liberty Mo (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Frances Smith Arnold

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F.E.

5. Color or race Wh

6. (a) Single, widowed, married, divorced Married

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 73 | Months | Days | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

MOTHER
14. Maiden name
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) 10/29/40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Oct day 17 year 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.

| | Duration |
|---|---|
| Immediate cause of death Tetanus | |
| Due to | |
| Due to 22 | |
| Other conditions (Include pregnancy within 3 months of death) | |

Major findings:
Of operations
Of autopsy

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence Oct 7, 1940

(c) Where did injury occur? Liberty (City or town), Clay (County), Mo (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home (Specify type of place)

While at work? Garden (e) Means of injury Nail in foot

23. Signature Gustendren (M. D. or other) MD

Address Liberty, Mo Date signed 10/28/40

SUPPLEMENTARY

5-34465