

Registration District No. 55

Primary Registration District No. 3011

1. PLACE OF DEATH:

(a) County Carroll  
(b) City or town Carrollton  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Southside Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 (Specify whether  
in this community 21 days years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Carroll  
(c) City or town Carrollton  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MATTIE HESTEL ARNOLD

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

4. Sex F. / 1 5. Color or race W. 6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Cass Arnold 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Mar. 4 1900  
(Month) (Day) (Year)

8. AGE: Years 46 Months 7 Days 21 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation at home

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name Tom Brotherton  
13. Birthplace unknown Mo  
(City, town, or county) (State or foreign country)  
14. Maiden name Sarah Stalgar  
15. Birthplace Wakenda Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Cass Arnold  
(b) Address Carrollton Mo.

17. (a) Burial (b) Date thereof 10/27/46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Oak Hills

18. (a) Signature of funeral director Stanley Gibson  
(b) Address Carrollton Mo.

19. (a) 10/27/46 (b) Mr. Herbert Calvert  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 25  
year 1946 hour 7 minute 5 P. M.

21. I hereby certify that I attended the deceased from June 12 1946 to Oct 25 1946  
that I last saw him alive on Oct 25 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary embolism Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy 111A

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 John C. DeWitt M.D. or other DO  
Address Carrollton Mo Date signed 10/27/46

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

RECEIVED

District Health Officer No. 8,

District File Number .....

Date Filed ..... 11-2-46 .....

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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 *Ben W. Gibson* .....

Licensed Embalmer No. *2961* .....

P. O. Address *Carrollton 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, fact should be so stated above.**