

Registration District No. **47**

Primary Registration District No. **3008**

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

1. PLACE OF DEATH:
 (a) County Callaway
 (b) City or town Fulton
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution State Hosp 1 2
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 days 11 mo 3 day
(Specify whether)
 In this community same
years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Miller
 (c) City or town Bagnell
(If outside city or town limits, write "RURAL")
 (d) Street No. 2
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME ARTHUR B VANN
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. **DATE OF DEATH:** Month Oct day 8
 year 1947 hour 9 minute 30 M.

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

21. I hereby certify that I attended the deceased from Oct 7, 1947 to Oct 8, 1947
 that I last saw him alive on Oct 7 and that death occurred on the date and hour stated above.
 Immediate cause of death Chronic Myo Carditis

8. AGE: Years 74 Months _____ Days _____
 If less than one day hr. _____ min. _____

Due to _____
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____
 Major findings: Of operations _____
 Of autopsy _____

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

10. Usual occupation farmer

11. Industry or business _____

MOTHER, FATHER
 { 12. Name DK 9
 { 13. Birthplace _____
(City, town, or county) (State or foreign country)
 { 14. Maiden name DK 9
 { 15. Birthplace _____
(City, town, or county) (State or foreign country)

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) (e) Means of injury

16. (a) Informant Records State Hosp 21

(b) Address Fulton

17. (a) Removal (b) Date thereof 10 16 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Columbiana Mo

18. (a) Signature of funeral director J. O. Roberts

(b) Address Columbiana Mo

19. (a) 10-16-1947 (b) Joan Moraskoff
(Date received local registrar) (Registrar's signature)

23. Signature J. O. Roberts 10 16 47
 Address Fulton Mo

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

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 10-24-47

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, fact should be so stated above.