

FILED AUG 12 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23289

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD—48

BIRTH NO.		REG. DIST. NO. 149		PRIMARY REG. DIST. NO. 1602		Registrar's No. 3261	
1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY Jackson			
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City		c. LENGTH OF STAY (In this place) 60 days		c. CITY (If outside corporate limits, write RURAL and give township) Kansas City		40 2	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1217 E. 4th St				d. STREET ADDRESS (If rural, give location) 1017 East 4th St			
3. NAME OF DECEASED (Type or Print) a. (First) Ben			b. (Middle) Arnold		c. (Last) Arnold		4. DATE OF DEATH (Month) (Day) (Year) July 19-49
5. SEX Male	6. COLOR OR RACE 2 Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Mar 17-1869	9. AGE (In years last birthday) 84		IF UNDER 1 YEAR Months Days Hours Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Miss Louise Hines 1017 E 4th St			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of Descending Colon</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Chronic myocardiitis</u>					INTERVAL BETWEEN ONSET AND DEATH 1 yr.
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 153*				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 6-15-1949, to 7-19-1949, that I last saw the deceased alive on 7-19-1949, and that death occurred at 10:30 P.M., from the causes and on the date stated above.							
23a. SIGNATURE Wm. A. Love M.D.				23b. ADDRESS 1820 E. 18th St.		23c. DATE SIGNED 7-28-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE July 28		24c. NAME OF CEMETERY OR CREMATORY K.C. School of Delapete		24d. LOCATION (City, town, or county) (State) 2105 Ind. Ave. K.C. Mo	
DATE REC'D BY LOCAL REG. 7-28-49		REGISTRAR'S SIGNATURE Shaldine Holmes		25. FUNERAL DIRECTOR'S SIGNATURE H.B. Moore		ADDRESS 1820 E. 18th St.	

1820 N 3.2

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.....

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed HB Moore.....

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.