

FILED MAR 6 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 4944
557

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
d. FULL NAME OF HOSPITAL OR INSTITUTION Near Clark Conv. Home		d. STREET ADDRESS (If rural, give location) 2839 Trost Ave	
3. NAME OF DECEASED (Type or Print) ARLING		4. DATE OF DEATH (Month) (Day) (Year) Feb 4 1950	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Dec 25-1873	
9. AGE (In years last birthday) 76		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
11. BIRTHPLACE (State or foreign country) Jamison Missouri		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Albert P. Michael		13b. MOTHER'S MAIDEN NAME Lou Warner	
14. NAME OF HUSBAND OR WIFE Amanda Michael		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 496-09-8816		17. INFORMANT'S SIGNATURE OR NAME Mrs. Ruby Snyder	
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) Lobar pneumonia ANTECEDENT CAUSES DUE TO (b) influenza DUE TO (c) unknown II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Scurvy & arteriosclerosis	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION No	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify) No	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 480 X	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) No		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 1946, to Feb 4, 1950, that I last saw the deceased alive on Feb 4, 1950, and that death occurred at 5 PM., from the causes and on the date stated above.			
23a. SIGNATURE M. B. Casbolt (Degree or title)		23b. ADDRESS 4000 Baltimore	
23c. DATE SIGNED 2/4/50		24. BURIAL, CREMATION, OR REMOVAL (Specify) Burial	
24b. DATE Feb 6-1950		24c. NAME OF CEMETERY OR CREMATORY Woodlawn	
24d. LOCATION (City, town, or county) (State) Independence - Mo.		25. SUPERVISOR'S SIGNATURE	
DATE REC'D BY LOCAL REG. 2-6-50		REGISTRAR'S SIGNATURE Geraldine Holmes	
25. SUPERVISOR'S SIGNATURE		ADDRESS 815 W. Maple Independence Mo.	

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

3008

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 _____

Licensed Embalmer No. 3156

P. O. Address Indep 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.