

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19439

State File No. _____
Registrar's No. 648

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000

1. PLACE OF DEATH a. COUNTY <u>Duchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>	c. LENGTH OF STAY (in this place) <u>264.5 m 182</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City 3178</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital no 2</u>		d. STREET ADDRESS (If rural, give location) <u>not given 702 Prospect Ave.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Oscar</u>	b. (Middle)	c. (Last) <u>Arnold</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>June 19, 1951</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>never married</u>	8. DATE OF BIRTH <u>March 2 1882</u>	9. AGE (In years last birthday) <u>69</u>	10. UNDER 1 YEAR Months <u>3</u> Days <u>17</u>	11. UNDER 1 HR. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gardener</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Trade Gardener</u>	11. BIRTHPLACE (State or foreign country) <u>Kansas City Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Godfried Arnold</u>	13b. MOTHER'S MAIDEN NAME <u>not given</u>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Charles Arnold</u>	ADDRESS <u>418 Bellefontaine K.C. Mo</u>
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Ischemic Myocarditis</u>		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arterio Sclerosis Nephroses Hypo</u>		
	DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Dementia Praecox</u>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>4221</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from May 1, 1951, to June 19, 1951, that I last saw the deceased alive on June 15, 1951, and that death occurred at 5 A. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>W. H. Blackman, M.D.</u>	23b. ADDRESS <u>State Hospital #2, City</u>	23c. DATE SIGNED <u>6-19-51</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>June 19, 1951</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Blackman Funeral Home</u>	24d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo</u>
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DATE REC'D BY LOCAL REG. <u>June 19, 1951</u>	REGISTRAR'S SIGNATURE <u>Carl C. Casper</u>	4446	25. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Blackman</u>	ADDRESS <u>St. James</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.....

..... Student Embalmer No.

working under my personal supervision.

Signed.....
Student Embalmer

Signed *James E. Hackleman*
Licensed Embalmer No. *4573*

P. O. Address *H. C., MD*

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.