

FILED JAN 30 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26789

State File No.

BIRTH NO. 5-865-54 REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 790B

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| 1. PLACE OF DEATH a. COUNTY Greene | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Christian | |
| b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN Springfield | | c. CITY OR TOWN "Rural" Porter | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. LENGTH OF STAY (In this place) 1 day 14 Hrs. | | e. STREET ADDRESS (If rural, give location) Route #1, Nixa | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Springfield Baptist | | | |

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|---|------------|-------------|------------------------|--|----------------------|
| 3. NAME OF DECEASED (Type or Print) Luanna | a. (First) | b. (Middle) | c. (Last) ARNDT | 4. DATE OF DEATH August 16-1954 | (Month) (Day) (Year) |
|---|------------|-------------|------------------------|--|----------------------|

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|----------------------|-------------------------------|---|---------------------------------------|--|---------------------------------|--------------------------------|-----------------|------|
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married | 8. DATE OF BIRTH Aug. 14, 1954 | 9. AGE (In years last birthday) 0 | if UNDER 1 YEAR Months 0 | if UNDER 12 Hrs. Days 1 | Hours 14 | Min. |
|----------------------|-------------------------------|---|---------------------------------------|--|---------------------------------|--------------------------------|-----------------|------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | 10b. KIND OF BUSINESS OR INDUSTRY -- | 11. BIRTHPLACE (City and State or Foreign Country) Springfield, Missouri | 12. CITIZEN OF WHAT COUNTRY? USA |
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|---|---|---|
| 13a. FATHER'S NAME Curtis F. Arndt | 13b. MOTHER'S MAIDEN NAME Dorothy Walker | 14. NAME OF HUSBAND OR WIFE None |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | 16. SOCIAL SECURITY NO. None | 17. INFORMANT'S SIGNATURE OR NAME Curtis F. Arndt, Rt. 1, Nixa, Mo. | ADDRESS |
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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, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH 2d |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congenital Atelectasis | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Premature Birth DUE TO (c) | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20: AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) | 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 8-14-54, to 8-16-54, that I last saw the deceased alive on 8-16-54, and that death occurred at 8:40a. m., from the causes and on the date stated above.

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| 23a. SIGNATURE (Degree or title) Wm. Busch M.D. | 23b. ADDRESS 609 Cherry Springfield Mo. | 23c. DATE SIGNED 8-21-54 |
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|---|-------------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE Aug. 17, '54 | 24c. NAME OF CEMETERY OR CREMATORY McConnell Cemetery | 24d. LOCATION (City, town, or county) (State) Nixa, Missouri |
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| DATE REC'D BY LOCAL REG. 8-24-54 | REGISTRAR'S SIGNATURE John Williamson | 25. FUNERAL DIRECTOR'S SIGNATURE Dean Harris | ADDRESS Clever, Mo. |
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WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

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.....
Signature of Student Embalmer

Signed..... *J. W. Harris*

*A Fluid Pack
was used*

Licensed Embalmer No. *4390*

P. O. Address *Cleveland, O.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.