

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-032229

STATE FILE NUMBER

FILED OCT. 10 1958

Registration District No. 107

Primary Registration District No. 3019

Registrar's No. 148

52
300
1-57

D. Zimmerman

1. PLACE OF DEATH a. COUNTY <u>Dunklin</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Dunklin</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kennett</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Malden</u> <u>03510</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Dunklin Co. Mem</u>		Length of stay in lb <u>1 day</u>	d. STREET ADDRESS (If outside, give location) <u>101 S. Douglass</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Keith</u> Middle <u>Arnold</u> Last <u>Arnold</u>			4. DATE OF DEATH Month <u>Sept</u> Day <u>22</u> Year <u>1958</u>		
---------------------------------------------------------------------------------------------------	--	--	----------------------------------------------------------------------	--	--

5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 29, 1958</u>	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months <u>24</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
--------------------	------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------	---------------------------------	-------------------------------------	--------------------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>	10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (City and state or country) <u>Malden Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
--------------------------------------------------------------------------------------------------------------	--------------------------------------------	-----------------------------------------------------------------	--------------------------------------------

13a. FATHER'S NAME <u>Kenneth Arnold</u>		13b. MOTHER'S MAIDEN NAME <u>Lois Beard</u>		14. NAME OF HUSBAND OR WIFE <u>Infant</u>	
---------------------------------------------	--	------------------------------------------------	--	----------------------------------------------	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Kenneth Arnold Malden, Mo.</u> Address
---------------------------------------------------------------------------------------------------------------------	----------------------------------------	---------------------------------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute gastroenteritis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____		
DUE TO (c) <u>5710</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
-----------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____
---------------------------------------------------	--------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------	----------------------------------------------------------

21. I attended the deceased from <u>22 Sept 58</u> to <u>22 Sept 58</u> and last saw her/him alive on <u>22 Sept 58</u> Death occurred at <u>10:00 P M</u> on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Joe A. Zimmerman, M.D.</u>	22b. ADDRESS <u>Kennett, Mo.</u>	22c. DATE SIGNED <u>9-24-58</u>
-------------------------------------------------------------------	-------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-24-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Malden</u>	23d. LOCATION (City, town, or county) (State) <u>Malden, Mo.</u>
------------------------------------------------------------	-----------------------------	---------------------------------------------------------	---------------------------------------------------------------------

24. FUNERAL DIRECTOR <u>McDaniel Kennett, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>9-29-58</u>	26. REGISTRAR'S SIGNATURE <u>Emil Hushman</u>
------------------------------------------------------	------------------------------------------------	--------------------------------------------------

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 Hubert B. Baird

Licensed Embalmer No. 4888

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