

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010262

STATE FILE NUMBER

FILED APR 6 1959 Registration District No. 247 Primary Registration District No. 4366 Registrar's No. 5

300
1-57

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|--|--|---|---|
| -1. PLACE OF DEATH a. COUNTY Newton | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Newton | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Granby | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Granby 0730 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Home | | Length of stay in 1b years | d. STREET ADDRESS (If outside, give location) None Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|---|--|--|--|--|--|
| 3. NAME OF DECEASED (Type or print) First Middle Last Felix Logan Arnald | | | 4. DATE OF DEATH Month Day Year 3-24-1959 | | |
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|-----------------------|----------------------------------|---|--|--|---|--------------------------------|
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 18, 1893 | 9. AGE (In years last birthday) 65 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Railroad Employee | | 10b. KIND OF BUSINESS OR INDUSTRY Railroad | 11. BIRTHPLACE (City and state or country) Bethpage, Mo. | 12. CITIZEN OF WHAT COUNTRY? USA |
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| 13a. FATHER'S NAME Pete Arnald | | 13b. MOTHER'S MAIDEN NAME Mary Jonson | 14. NAME OF HUSBAND OR WIFE Leona Arnald | | |
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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. | 17. INFORMANT Address Mrs. Leona Arnald Granby, Missouri | | |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metrial Insufficiency DUE TO (b) Pulmonary Tuberculosis DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 002X | | | | INTERVAL BETWEEN ONSET AND DEATH 30445 2 yrs | |
| 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"/> | |

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| 20a. ACCIDENT SUICIDE HOMICIDE <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | | |
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| 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. | | | 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | |
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|--|--|------------------------------|--|--------|-------|
| 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 **1-12-1957** to **3-24-59** and last saw ^{her}him alive on **3-22-59**
Death occurred at **4:30** a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) Melvin M. Cullough DO2 | | 22b. ADDRESS Neosho Mo. | | 22c. DATE SIGNED 3/31/59 |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) (State) | |
| BURIAL | 3-27-59 | Granby Memorial | | Granby Mo | |

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| 24. FUNERAL DIRECTOR ADDRESS Culver-Shepherd Granby Mo. | | 25. DATE RECD. BY LOCAL REG. Apr. 21 1959 | 26. REGISTRAR'S SIGNATURE M. H. Young | | |
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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

APR 16 1955

MISSOURI
DEPARTMENT OF HEALTH
DIVISION OF ANATOMY

Late Miss

459-51

Wendell

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 *Floyd E. Shumaker*

Licensed Embalmer No. *4923*
P. O. Address *Boys' Club, 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.