SOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-045904

STATE FILE NUMBER

AMENDED

Registration District No. 4448 Primary Registration District No. 6024 Registrar's No. 164

FILED DEC 18 1961

1. PLACE OF DEATH
a. COUNTY Ray
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Lawson
Length of stay in 1b: 5 years
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Street Listed
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY Ray
c. CITY OR TOWN Lawson
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) Street Listed
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First WILEY Middle CALVIN ARROWOOD Last

4. DATE OF DEATH: Month Dec Day 9 Year 1961

5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: May 5, 1874
9. AGE (last birthday): 87
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): Polo Mo
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: James Arrowood
13b. MOTHER'S MAIDEN NAME: Martha Hyder
14. NAME OF HUSBAND OR WIFE: Mollie Arrowood

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.: 489-44-0643
17. INFORMANT: Roy Arrowood Address: San Antonio Texas

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Respiratory Failure	36 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Cerebral Hemorrhage	3-4 days
DUE TO (c)	Hypertension	Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Diabetes & Arteriosclerosis

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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~~ 12-8-61 to 12-9-61 and last saw ~~her~~ him alive on 12-8-61
Death occurred at Approx 10:10 p m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): A. L. Faulk DO.
22b. ADDRESS: Lawson, Mo.
22c. DATE SIGNED: 12-11-61

BY AFFIDAVIT OF

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Dec. 12, 1961
23c. NAME OF CEMETERY OR CREMATORY: Union Cemetery
23d. LOCATION (City, town, or county) (State): Ray Co. Mo.

24. FUNERAL DIRECTOR ADDRESS: Jarman Funeral Home Lawson Mo
25. DATE REGD. BY LOCAL REG.: 12-14-1961
26. REGISTRAR'S SIGNATURE: Maleel Jackson

(Licensed Embalmer's Statement on Reverse Side)

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 Ralph Van Landingham

Licensed Embalmer No. 4099

P.O. Address Graham, Georgia

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.