

1936 APR 12 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

791
1008

9062
Do not use this space.

1. PLACE OF DEATH

(a) County..... 3 Registration District No.....
(b) Township..... 1 Primary Registration District No..... Registered No..... 2827
(c) City or St. St. Louis (d) Street No. Enroute City Hospital No. 1. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

654 Fred Arnold
(a) Residence, No. 4117 Donovan Ave. St. 14 (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Elizabeth Arnold
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) About 1884
7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
54 About

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Unemployed
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Mo. c

FATHER
13. NAME Fred Arnold

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER
15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT Mrs. Elizabeth Arnold
(ADDRESS) 4117 Donovan Ave.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Old St. Peter & Paul DATE 3-27 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Kriegshauser Mortuary
4104 Manchester Ave.

20. FILED MAR 25 1939
J. B. Brubaker Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 24 19 39

22. I HEREBY CERTIFY, That I attended deceased from 19..... to 19.....
I last saw h..... alive on..... 19..... Death is said to have occurred on the date stated above, at 10:50 A.M.
The principal cause of death and related causes of importance were as follows:

Pulmonary Thrombosis;
Contrib: Chronic Hypertrophic
Bronchitis.

Other contributory causes of importance
Date of onset

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury..... 19.....
Where did injury occur?..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury..... see above
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?
If so, specify.....
(Signed) Joseph M. Quinn M.D.
(Address) Deputy Coroner

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....
Edwin M. Herriott

Licensed Embalmer No.....
3024

P. O. Address.....

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, above space should be left blank.