DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 396

Registration District No. 201 Primary Registration District No. Registrar's No. 396

1. PLACE OF DEATH: 1003 FEB 17 19
(a) County
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 5366 Wells Ave. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 40
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County
(c) City or town St. Louis 6
(If outside city or town limits, write "RURAL")
(d) Street No. 5366 Wells
(If rural, give location)
(e) If foreign born, how long in U. S. A.? Life years.

3. (a) PRINT FULL NAME Harriott T. Arnold 654
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Jacob Arnold
6. (c) Age of husband or wife if alive years
7. Birth date of deceased unknown (Month) (Day) (Year)

8. AGE: Years About 75 Months Days If less than one day hr. min.

9. Birthplace Tomalco (City, town, or county) Ill. (State or foreign country)
10. Usual occupation At Home
11. Industry or business
FATHER 12. Name Jonathan Floyd
13. Birthplace (City, town, or county) Kentucky (State or foreign country)
MOTHER 14. Maiden name Amanda Goodson
15. Birthplace (City, town, or county) Ill. (State or foreign country)
16. (a) Informant's own signature Belle Simmons
(b) Address 5366 Wells ave
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-16-40 (Month) (Day) (Year)
(c) Place: burial or cremation Bellefontaine
18. (a) Signature of funeral director Alexander & Son
(b) Address 6175 Delmar Blvd.
19. (a) JAN 15 1940 (Date received by Registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. 13 day
year 1940 hour 6 30 minute A M.
21. I hereby certify that I attended the deceased from Jan. 5
Jan 12, 1940, to, 1940,
that I last saw him alive on Jan. 12, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral Hemorrhage	8 days
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury
23. Signature Rose Minnie Rose (M. D. or other)
Address 5411 Easton Ave Date signed 1/14/40

(Licensed Embalmer's Statement on Reverse Side)

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.

X19511

St. Bernard Hosp

5411 Easton

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 Jos. E. McCulloh

Licensed Embalmer No. 2460

P. O. Address 6175 Delmar

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.