

1. PLACE OF DEATH:

(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:
St. Anthony Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 21 Days
(Specify whether
In this community 25 years
years, months or days)

8. (a) PRINT FULL NAME William P. Arrington 652

3. (b) If veteran, name war ---- 3. (c) Social Security No. 488-01-0744

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widower
6. (b) Name of husband or wife Ethel 6. (c) Age of husband or wife if alive -- years
7. Birth date of deceased August 14, 1883
(Month) (Day) (Year)

8. AGE: Years 56 Months 10 Days 20 If less than one day hr. _____ min.

9. Birthplace Unknown Ohio
(City, town, or county) (State or foreign country)

10. Usual occupation Bookkeeper

11. Industry or business St. Louis and Ofallon Coal Co.

12. Name Louis Arrington

13. Birthplace Ohio
(City, town, or county) (State or foreign country)

14. Maiden name Mary Hughes

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant William P. Arrington

(b) Address 137 Center Avenue, Evanston, Illinois

17. (a) Burial (b) Date thereof 6/7/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Wacker-Welderle

(b) Address 2331 S. Broadway

19. (a) JUN 6 1940 (b) J. P. [Signature]
(Date received from informant) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 3664 Hartford
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 4
year 1940 hour 8 minute 35 P. M.

21. I hereby certify that I attended the deceased from May 1940 to June 4, 1940
that I last saw him alive on June 4, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: Bronchial Pneumonia

Due to Streptococcus Group
non alpha hemolytic

Other conditions: 1150
(Include pregnancy within 3 months of death)

Major findings: 1150
Of operations _____

Of autopsy no

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? _____

While at work? _____ (Specify type of place)
(a) Manner of injury 1

23. Signature Edwin J. [Signature] M. D. or other _____
Address 4603 N. Douglas Date signed 6/5/40

Duration
Physician
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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..... *Frank J. Meland.*
Licensed Embalmer No..... *2645*
P. O. Address..... *St Louis 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 this body is not embalmed, above space should be left blank.