

FEB 25 1941

Registration District No. 791

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Deaconess Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Life
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME James August Arndt

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Oct 30 1940
(Month) (Day) (Year)

8. AGE: Years _____ Months 2 Days 10 If less than one day hr. _____ min. _____

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business Nil

MOTHER FATHER { 12. Name C. E. Arndt
13. Birthplace Wisconsin
(City, town, or county) (State or foreign country)
14. Maiden name Alba Burton
15. Birthplace Idaho
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature C. E. Arndt
(b) Address Crescent, Mo.

17. (a) Cremation (b) Date thereof 1 10 41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla

18. (a) Signature of funeral director Louis H. Bopp, M.D.

(b) Address 131 W. Bismarck St. Kirkwood, Mo.

19. (a) J. F. Budick (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 9 1941
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from 10:30-40, 1941, to 1-9-41, 1941;
that I last saw him alive on 1-9-41, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death
Spina Bifida
Due to Constitutional

Other conditions (Include pregnancy within 3 months of death) 101

Major findings: Of operations _____
Of autopsy _____

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) (e) Means of injury _____

23. Signature W. H. Mead (M. D. or other) _____
Address 1000 Thrift Bldg Date signed 1-9-41

WHITE PRINT—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

1 X1931

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.....

Louis H. Boff....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *Louis H. Boff*
Licensed Embalmer No. *921*
P. O. Address *Kirkwood*

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.