

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 2049

FILED SEP 21 1943

District No. 317

Primary Registration District No. 6076

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Pine Lawn, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Mother of Good Council Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community _____ years, months or days

3. (a) PRINT FULL NAME Flora Arendt

3. (b) If veteran, name war None 3. (c) Social Security No. None

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

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

7. Birth date of deceased September 25 1861
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
81 11 15 hr. _____ min.

9. Birthplace Unavailable Germany
(City, town, or county) (State or foreign country)

10. Usual occupation House Keeper

11. Industry or business _____

MOTHER { 12. Name Unavailable
FATHER { 13. Birthplace Unavailable Unavailable
(City, town, or county) (State or foreign country)
14. Maiden name Unavailable
15. Birthplace Unavailable Unavailable
(City, town, or county) (State or foreign country)

16. (a) Informant Herman Strope

(b) Address Meta, Missouri

17. (a) Burial (b) Date thereof 9/11/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Argyle, Missouri

18. (a) Signature of funeral director Albert H. Hoppe, Inc

(b) Address 4700 Washington Blvd.

19. (a) SEP 13 1943 (b) E. J. Mc Harrigan
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Osage
(c) City or town Koeltztown
(If outside city or town limits, write "RURAL")
(d) Street No. Koeltztown Mo. (near Jefferson City, Mo.)
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 10
year 1943 hour 2:35 PM minute _____ M.

21. I hereby certify that I attended the deceased from Aug-17-43
9/10/, 1943, to _____, 19____

that I last saw h. or alive on 9/9/, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Myo-Carditis
Endo-Carditis- Generalized
Arterio Sclerosis Paralysis

Due to agitans.

Initin-

Due to Extreme-senile type.

Died in the home of the incurable.

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

Major findings: Illness

Of operations _____
Of autopsy No.

Duration

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 No.
(c) Where did injury occur? Illness.
(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) Means of injury _____
23. Signature E. J. Mc Harrigan (M. D. or other) _____
Address 377 S. Harrison St. Date signed _____

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

9600

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