

FILED FEB 24 1945

Registration District No. 379

Primary Registration District No. 3070

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Webster Groves
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution 802 Holland
(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

Annie Arnold

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife James Arnold 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 6 1861
(Month) (Day) (Year)

8. AGE: Years 83 Months 8 Days 4 If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Whitelaw
13. Birthplace Illinois
(City, town, or county) (State or foreign country)
14. Maiden name Francis
15. Birthplace Neely's Landing Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Marguerite Hardeman
(b) Address 4169 Conright Ave
17. (a) Burial (b) Date thereof Feb. 14 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St. St. Peter's Cem.

18. (a) Signature of funeral director Russell Undt. Co.
(b) Address 2732 Pine Street
19. (a) 2/14/45 (b) E. G. McAvoy MD
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis
(c) City or town Webster Groves 96
(If outside city or town limits, write "RURAL")
(d) Street No. 802 Holland Ave. 7
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____ X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 7th
year 1945 hour _____ minute 70 M.

21. I hereby certify that I attended the deceased from 2/2/40 1940 to 2/10/45 1945
that I last saw him alive on 2/10/45 1945
and that death occurred on the date and hour stated above.
Immediate cause of death Bronchitis Pneumonia 23 days

Due to acute respiratory infection
Due to fracture 31 days

Other conditions fracture of hip
(include pregnancy within 3 months of death)

Major findings: Of operations _____ Of autopsy _____
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature P. L. ... (M.D. or other) _____
Address 2438 ... Date signed 2/12/45

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 *Jaal Russell*
Licensed Embalmer No. *4112*
P. O. Address *H. Jarvis*

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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7055
Registrar's No. 485-

Registration District No. 317 Primary Registration District No. 3070

1. PLACE OF DEATH:

(a) County St Louis
(b) City or town Webster Groves
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME

Annie Arnold

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

4. Sex F 5. Color or race B 6. (a) Single, widowed, married, divorced wid

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

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years 80 Months _____ Day _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Day 10
year 19 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____
that I last saw him _____ alive on _____, 19____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____

Due to _____

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

Major findings:
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence not 15-84

(c) Where did injury occur Webster Groves St. Louis Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? home

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature P. J. Payne (M. D. or other) _____

Address Webster Groves Date signed 12/10/95

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

SUPPLEMENTARY

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

PHYSICIAN

Underline the cause to which death should be charged statistically.

