. S. No. 2
OM—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 25388

FILED SEP 14 1945

Registration District No. 918

Primary Registration District No. 1003

Registrar's No. 7735

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: Missouri Baptist Hospital
(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 Illinois (b) County Williamson 999

(c) City or town Marion 11
(If outside city or town limits, write "RURAL")

(d) Street No. 419 Calumet Ave. N.R.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Mary Ann Arnoldi

3. (b) If veteran, name war Nil

3. (c) Social Security No. Unknown

4. Sex Female

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 December (Month) 23 (Day) 1887 (Year)

8. AGE: Years 57 Months 8 Days 9 If less than one day hr. min.

9. Birthplace Mine Lamotte (City, town, or county) Missouri (State or foreign country)

10. Usual occupation School Teacher

11. Industry or business

FATHER
12. Name Carl F. Arnoldi
13. Birthplace Unknown (City, town, or county) Germany (State or foreign country) 4

MOTHER
14. Maiden name Mary A. Russell
15. Birthplace Unknown (City, town, or county) Kentucky (State or foreign country)

16. (a) Informant Martin L. Arnoldi

(b) Address Marion, Ill.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-6-45 (Month) (Day) (Year)

(c) Place: burial or cremation Farmington, Missouri

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

(b) Address 4700 Washington Blvd.

19. (a) SEP 4 1945 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 2 year 1945 hour 5:10 minute P. M.

21. I hereby certify that I attended the deceased from Aug. 6, 1945, 19, to demise, 19; that I last saw her alive on 9/1/45, 19; and that death occurred on the date and hour stated above.

Immediate cause of death Lobar pneumonia

Due to Acute disseminated lupus erythematosus

Due to

Other conditions (Include pregnancy within 3 months of death) 108

Major findings:
Of operations

Of autopsy To be reported

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

(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 [signature] (M. D. or other)

Address MO. Baptist Hosp. Date signed 9-3-45

(Licensed Embalmer's Statement on Reverse Side)

MAR 14 1945

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.....

Licensed Embalmer No. 3575

P. O. Address.....

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.