

U.S. No. 2
FORM-5-43
REV. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. _____
Registrar's No. **10601**

FILED DEC 24 1946
Registration District No. _____

Primary Registration District No. _____

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

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: Barnes Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 13 days
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME JEAN BRADFORD ARNOT

3. (b) If veteran, name war No

3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Lillian Arnot

6. (c) Age of husband or wife if alive 53 years

7. Birth date of deceased June 28 1898
(Month) (Day) (Year)

8. AGE: Years Months Day If less than one day

48 5 17 hr. _____ min.

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

10. Usual occupation Contractor

11. Industry or business Pipe Line Construction

MOTHER FATHER { 12. Name Lykirby Arnot

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

14. Maiden name Ida Josephine Collier

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

16. (a) Informant Lillian Arnot

(b) Address 7219a S. Michigan Ave.

17. (a) Burial (b) Date thereof 12-9-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Edgar Springs, Mo.

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

(b) Address 4700 Washington Blvd.

19. (a) DEC 10 1946 (Date received by registrar)

J. F. Budick (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. 7219a S. Michigan
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 9
year 1946 hour 9 minute 10 a.m.

21. I hereby certify that I attended the deceased from Nov. 26 1946 to Dec 9 1946

that I last saw him alive on December 9 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Infarction of myocardium

Due to Arteriosclerotic thrombosis

Due to _____

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

PHYSICIAN _____

Major findings: Of operations _____

Of autopsy Same as above

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 J. F. Budick (M. D. or other) _____

Address Barnes Hospital Date signed 12-9-46

10907

AUG 4 1950

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. *4033*

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, fact should be so stated above.