

FILED JAN 7 1947

1003

Registration District No. _____ Primary Registration District No. _____

318

1. PLACE OF DEATH:
 (a) County _____
 (b) City or town St. Louis, Mo.
 (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)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Illinois (b) County Macoupin
Carrollton
 (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 Robert Taylor Arnold
 3. (b) If veteran, name war N11
 3. (c) Social Security No. 318-20-5196

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month December day 19
 year 1946 hour 12 minute 20 A.M.

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Separated
 6. (b) Name of husband or wife Ruth Arnold
 6. (c) Age of husband or wife if alive Unk. years
 7. Birth date of deceased November 3 1882
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from
December 5, 1946, to December 19, 1946
 that I last saw him alive on December 19, 1946
 and that death occurred on the date and hour stated above.

8. AGE:	Years.	Months	Days	If less than one day
	<u>64</u>	<u>1</u>	<u>16</u>	hr. _____ min. _____

Immediate cause of death Congestive failure
 Due to Arteriosclerotic heart disease
 Due to _____

9. Birthplace Macoupin County Illinois
 (City, town, or county) (State or foreign country)
 10. Usual occupation Unknown

Other conditions Coronary sclerosis
 (Include pregnancy within 3 months of death)
general arteriosclerosis
 Major findings: _____
 Of operations: Myocardial infarction

11. Industry or business _____
 12. Name John Arnold
 13. Birthplace Macoupin County Illinois
 (City, town, or county) (State or foreign country)
 14. Maiden name Sarah Banning
 15. Birthplace Illinois
 (City, town, or county) (State or foreign country)

Of autopsy None performed
 Underline the cause to which death should be charged statistically.

16. (a) Informant William Arnold
 (b) Address Carrollton, Illinois
 17. (a) Removal (b) Date thereof 12-10-46
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Carrollton, Illinois

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? _____

18. (a) Signature of funeral director Albert H. Hoppe
4700 Washington Blvd.
 (b) Address _____
 19. (a) DEC 20 1946 (b) J. F. Bredeel
 (Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)
 (e) Means of injury _____
 23. Signature J. F. Bredeel (M. D. or other)
 Address Barnes Hospital Date signed 12-19-46

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

40906

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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.....

Henry M. Brammer

Licensed Embalmer No..... *4200*

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.