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Rev. 5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED JAN 27 1947

318

Primary Registration District No. \_\_\_\_\_

1003

Registrar's No. \_\_\_\_\_

403

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

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

(d) Length of stay: In hospital or institution 10 days  
(Specify whether years, months or days)

In this community 20 yrs  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
(If outside city or town limits, write "RURAL")

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 6139 Pershing  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME WILLIAM ARENSON

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Anna Arenson 6. (c) Age of husband or wife if alive (unk) years

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 12th  
year 1947 hour 10 minute 40 a. M.

21. I hereby certify that I attended the deceased from 1/31/47  
\_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_

that I last saw him alive on 1/12/47 \_\_\_\_\_ 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death bronchopneumonia  
Dyspnea

8. AGE: Years Months Days If less than one day  
ab. 81 hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Poland 4  
(City, town, or county) (State or foreign country)

10. Usual occupation Merchant

11. Industry or business Furniture

12. Name (unk) Arenson 4

13. Birthplace Poland 4  
(City, town, or county) (State or foreign country)

14. Maiden name Molly (unk)

15. Birthplace Poland 4  
(City, town, or county) (State or foreign country)

16. (a) Informant Bert A. Arenson  
(b) Address 5727 Kingsbury

17. (a) burial (b) Date thereof 1/14/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chesed Shel Emeth

18. (a) Signature of funeral director Berger Memorial  
715 McPherson  
JAN 14 1947

19. (a) \_\_\_\_\_ (b) J. J. Brueck  
(Date received local registrar) (Registrar's signature)

Due to General atherosclerosis  
myocarditis acute from Chol.

Due to Cerebral hemorrhage

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 W. F. Mistachkin (M. D. or other) \_\_\_\_\_  
Address 448 Washington Date signed 1/13/47

(Licensed Embalmer's Statement on Reverse Side)

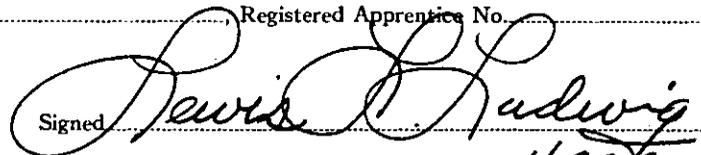
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**STATEMENT BY LICENSED EMBALMER**

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 .....

Licensed Embalmer No. 4229.....

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.**