

S. No. 2
FILED
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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6823**
Registrar's No. **2123**

Registration District No. **318** Primary Registration District No. **1003**

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:
City 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 **Missouri** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **3834-Blair Avenue**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No) _____
If yes, name country _____

3. (a) PRINT FULL NAME **Arthur James Post Jr.**
(b) If veteran, name war **None**
(c) Social Security No. **None**
4. Sex **M** 5. Color or race **W**
6. (a) Single, widowed, married, divorced **S**
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Dec. 19 1946**
(Month) (Day) (Year)
8. AGE: Years Months Days If less than one day
2 9 hr. min.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Feb** day **28th** year **1947** hour **12** minute **15** P.M.
21. I hereby certify that I attended the deceased from **Feb. 26/47** 19____ to **Feb 28/47** 19____
that I last saw him alive on **Feb 28th/47** 19____ and that death occurred on the date and hour stated above.

Immediate cause of death **Intermittent Pneumonia** Duration **1 day**
Due to **acute Bronchitis** **3 day**
Due to _____

9. Birthplace: **St. Louis Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **nil**

11. Industry or business _____
12. Name **Arthur J. Post Sr.**
13. Birthplace **Irondale Mo.**
(City, town, or county) (State or foreign country)
14. Maiden name **Leola M. Maze**
15. Birthplace **Wichita Kans.**
(City, town, or county) (State or foreign country)

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.

16. (a) Informant **Arthur J. Post Sr.**
(b) Address **3834-Blair Ave-St. Louis Mo.**

17. (a) **Burial** (b) Date thereof **3-3-1947**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Valhalla Cemetery**

18. (a) Signature of funeral director **Blumman Bros. Inc.**
2504 Woodson Rd-Overland, Mo.
(b) Address _____

19. (a) **WAR** (b) **J. F. Brebeck**
(Date received local registrar) (Registrar's signature)

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) (c) Means of injury _____
23. Signature **J. F. Brebeck** (M. D. or other) _____
Address **1415 Salisbury St. City** Date signed **3/28/47**

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

CE 3376

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..... *Harold K. Bram*.....
Licensed Embalmer No..... *4337*.....
P. O. Address..... *Overland, 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.