

3. No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 21 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11883
State File No. _____
Registrar's No. 603

Registration District No. 317 Primary Registration District No. 6076

1. PLACE OF DEATH:
(a) County Rock ST. LOUIS
(b) City or town Rural
(c) Name of hospital or institution: Robt Koch Hospital
(d) Length of stay: In hospital or institution 64 days
In this community one year? (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St Louis
(d) Street No. 2032 1/2 Fallon
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME ANNA DOROTHY ARRINGTON
3. (b) If veteran, name war _____ 3. (c) Social Security No. yes

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 3 day 11
year 1947 hour 5 minute 40 A. M.
21. I hereby certify that I attended the deceased from 1-7, 1947, to 3-11, 1947, that I last saw her alive on 3-10, 1947, and that death occurred on the date and hour stated above.

4. Sex FEM 5. Color or race Col
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 9-1-31
(Month) (Day) (Year)

Immediate cause of death Pulmonary Tbc. F.A.
Due to 136
Due to _____

8. AGE: Years Months Days If less than one day
15 6 10 hr. min.

Other conditions Tbc. Meningitis
(Include pregnancy within 3 months of death) 5 mos?

9. Birthplace Sheward Miss
(City, town, or county) (State or foreign country)

Major findings: _____
Of operations _____
Of autopsy As above
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

10. Usual occupation Student
11. Industry or business _____

12. Name Harvey Arrington
13. Birthplace Miss
(City, town, or county) (State or foreign country)

14. Maiden name Ann Lee Johnson
15. Birthplace Birmingham Ala
(City, town, or county) (State or foreign country)

16. (a) Informant Record of Jt
(b) Address _____

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 0

17. (a) Buried (b) Date thereof 3-18-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Green Wood Cemetery

18. (a) Signature of funeral director H. S. Howe
(b) Address 2930 Dickson Street
19. (a) 3-17-47 (b) Paul H. Gallen
(Date received local registrar) (Registrar's signature)

23. Signature Bernard Friedman (M. D. or other) m-p
Address Robt Koch Hosp Date signed 3/11/47

(Licensed Embalmer's Statement on Reverse Side) Rock, Mo

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

MOTHER FATHER

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 Arthur L. Hilliard

Licensed Embalmer No. 4221

P. O. Address 1154 Bayard

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.