

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Registration District No. 318

Primary Registration District No. 1003

**1. PLACE OF DEATH:**

(a) County St. Louis Mo.  
 (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, 0  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 3 days  
 (Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo. (b) County St. Louis  
 (c) City or town St. Louis  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 2133 So. Jefferson Ave.  
 (If rural, give location)  
 (e) Citizen of foreign country? 23 (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** FRANK ARB  
 3. (b) If veteran, name war No  
 3. (c) Social Security No. ?

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month July day 9  
 year 1948 hour 3 minute 25 A.M.

21. I hereby certify that I attended the deceased from July 6, 1948, to July 9, 1948  
 that I last saw him alive on July 9, 1948  
 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White  
 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 Feb. 17, 1890  
 (Month) (Day) (Year)

Immediate cause of death  
Edema of Brain Duration 18 hrs.  
 Due to Metastatic Tumor 11 yrs.  
Postoperative  
 Due to MI  
 Other condition Arteriosclerosis  
 (Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day  
58 4 22 hr. \_\_\_\_\_ min.

9. Birthplace Missouri (State or foreign country)  
 10. Usual occupation Motorman

11. Industry or business Ill. Traction Syst. R.R.  
 12. Name John Arb  
 13. Birthplace Missouri (State or foreign country)  
 14. Maiden name Magdalene Bolgel  
 15. Birthplace Missouri (State or foreign country)

16. (a) Informant Mrs. Lena Baker  
 (b) Address 2005 John's Ave.  
 17. (a) Burial (b) Date thereof July 12/48  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
Sacred Heart Cem., Florissant, Mo.  
 (c) Place: burial or cremation

Major findings: Metastatic Tumor  
 Of operations  
 Of autopsy Frontal Defect - Tot. op.  
Edema of Brain

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?  
 (Specify type of place) \_\_\_\_\_  
 While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
 Signature Joseph C. Paden Jr. (M. D. or other) M.D.  
 Address Barnes Hospital Date signed 7/9/48

18. (a) Signature of funeral director Jos. W. Clark  
 (b) Address 1125 Hodiamont Ave.  
 19. (a) JUL 10 1948  
 (Date received local registrar) (Registrar's signature) J. F. Brinded

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.....

*Anthony Brown*

Registered Apprentice No. *102*

working under my personal supervision.

Signed *Alfred J. Bedeker*

Licensed Embalmer No. *2663*

P. O. Address *1125 Hodiament Ave.*

**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.**