

FILED FEB 23 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5878

BIRTH NO. 124 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 6075 Registrar's No. 55

1. PLACE OF DEATH a. COUNTY St. Francois		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY City of St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Farmington RURAL St. Francois		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (In this place) 17 yr 1 mo 8 days			
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION State Hospital No. 4		d. STREET ADDRESS (If rural, give location) City Sanitarium, 5400 Arsenal St.	

3. NAME OF DECEASED (Type or Print) a. (First) BERNARD b. (Middle) ARENSMEYER c. (Last) ARENSMEYER			4. DATE OF DEATH (Month) (Day) (Year) February 10, 1949		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	
8. DATE OF BIRTH May 4, 1882		9. AGE (In years last birthday) 66		10. IF UNDER 1 YEAR Days 9	
11. IF UNDER 1 HRS. Hours 6		12. IF UNDER 1 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Mining		11. BIRTHPLACE (State or foreign country) Germany 4	
12. CITIZEN OF WHAT COUNTRY? Germany					

13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE None	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes Spanish-American		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Farmington, Mo. Records, State Hospital No. 4	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ruptured Left Ventricle		DUPLICATE (b) Coronary Thrombosis			Instantaneous	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUPLICATE (c) Dementia Praecox Psychosis			5 days	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					28 years	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from Jan. 2, 1932, to February 10, 1949, that I last saw the deceased alive on February 10, 1949, and that death occurred at 5:10 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <i>James H. Hoctor, M.D.</i>		23b. ADDRESS Farmington, Mo. State Hospital No. 4		23c. DATE SIGNED Feb 12, 1949	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Feb. 12, 1949		24c. NAME OF CEMETERY OR CREMATORY Anatomy Department Washington University	
24d. LOCATION (City, town, or county) (State) St. Louis, Missouri					

DATE REC'D BY LOCAL REG. Feb. 17, 1949		REGISTRAR'S SIGNATURE <i>Esther Rude</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Via Cozean Funeral Home, Farmington, Mo.	
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(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10-48

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RECEIVED

Health Officer No. 4

District File Number 249-27

Date Filed 2-21-4

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____

Student Embalmer

Signed _____

C. Hozen

Licensed Embalmer No. 4084

P. O. Address Farmington

Washington U. Medical School

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.