

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42247**

BIRTH NO. **82630-49** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **13826**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission). a. STATE MISSOURI b. COUNTY JEFFERSON	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS	c. LENGTH OF STAY (in this place) 1	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN PEVELY	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS MATERNITY		d. STREET ADDRESS (If rural, give location) W.K. R.R. # 1	

3. NAME OF DECEASED (Type or Print) a. (First) INFANT b. (Middle) MALE c. (Last) ARNOLD			4. DATE OF DEATH (Month) (Day) (Year) DECEMBER 15, 1949		
5. SEX MATE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH DECEMBER 15, 1949		9. AGE (In years last birthday) 3 F UNDER 1 YEAR Months F UNDER 1 WEEK Hours Min. 25
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ST. LOUIS MISSOURI	
12. CITIZEN OF WHAT COUNTRY? US					

13a. FATHER'S NAME JOE ARNOLD		13b. MOTHER'S MAIDEN NAME MATHILDA LEE BOYER		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS JOE & MATHILDA ARNOLD, SAME AS ABOVE	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Precipitous labor			
		DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Mother a hypertensive & severe preclampsia			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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) Pevely Jefferson MO	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR 760.0	

22. I hereby certify that I attended the deceased from **12-15-49 10** to **12-15-49 10**, that I last saw the deceased alive on **12-15-49**, and that death occurred at **3:50 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Carl Woolsey, M.D.		23b. ADDRESS		23c. DATE SIGNED	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 12-16-49		24c. NAME OF CEMETERY OR CREMATORY Festus, Mo.	

DATE REC'D BY LOCAL REG. DEC 16 1949		REGISTRAR'S SIGNATURE J. B. Foster		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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..... **No Embalm**

Licensed Embalmer No.

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.