

FILED MAR 23 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 11226
2467

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		a. STATE Missouri	b. COUNTY Jefferson
c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Barnhardt 1500	
d. FULL NAME OF HOSPITAL OR INSTITUTION Alexian Bros. Hospital		d. STREET ADDRESS (If rural, give location) 1	
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)
a. (First) HERMAN	b. (Middle) ****	c. (Last) VON ARX	Mar. 12, 1950
5. SEX Male <input type="radio"/>	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 18, 1879
9. AGE (In years last birthday) 71		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardener	11. BIRTHPLACE (State or foreign country) Hermann, Missouri 0
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Gottlieb Von Arx		13b. MOTHER'S MAIDEN NAME Anna Fricker	14. NAME OF HUSBAND OR WIFE Minnie
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Minnie Von Arx Barnhardt, Missouri
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral aneurysm of the Transverse Cerebellar Artery		INTERVAL BETWEEN ONSET AND DEATH 6 Months	
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b)	
DUE TO (c)		II. OTHER SIGNIFICANT CONDITIONS	
Conditions contributing to the death but not related to the disease or condition causing death.		19a. DATE OF OPERATION 3/5/50	
19b. MAJOR FINDINGS OF OPERATION Carcinoma of large bowel		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)	1534
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 3/3/1950 , to 3/12, 1950 , that I last saw the deceased alive on 3/11, 1950 , and that death occurred at 6:25 Am. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Dr. J. B. Janssen M.D.		23b. ADDRESS 7619 Jay	23c. DATE SIGNED 3/12/50
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Mar. 15, 1950	24c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park	24d. LOCATION (City, town, or county) (State) IO180 Gravois Afton, Missouri
DATE REC'D BY LOCAL REG. MAR 14 1950	REGISTRAR'S SIGNATURE J. B. Janssen	25. FEDERAL DIRECTOR'S SIGNATURE ADDRESS C. Hoffmeister U&L Co. 7814 S. Broadway	

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

Harry J. Schenck

Licensed Embalmer No. *2679*

P. O. Address *7814 Broadway*

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.