

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **11278**BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 471

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give town) <u>JEFF BRKS, MO.</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>ST. LOUIS</u>	
c. LENGTH OF STAY (in this place) <u>21 DAYS</u>		d. STREET ADDRESS (If rural, give location) <u>1950 LILBURN</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>VETERANS ADM. HOSPITAL</u>			
3. NAME OF DECEASED a. (First) <u>LESTER</u>		b. (Middle) <u>H.</u>	
c. (Last) <u>ARNING</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>2-21-52</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>1-16-92</u>
9. AGE (In years last birthday) <u>60 YRS</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AUTO MECHANIC</u>	
10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>ST. LOUIS, MISSOURI</u>	
13a. FATHER'S NAME <u>CHARLES ARNING</u>		13b. MOTHER'S MAIDEN NAME <u>CATHERINE KNOLLMAN</u>	
14. NAME OF HUSBAND OR WIFE <u>ELSTE ARNING</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>494-36-4763</u>	
(If yes, give war or dates of service) <u>WW-I</u>		17. INFORMANT'S SIGNATURE OR NAME <u>VA HOSPITAL RECORDS</u>	
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) <u>MASSIVE HEMORRHAGE</u> ANTECEDENT CAUSES DUE TO (b) <u>DUODENAL ULCER</u> <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i> <u>PULMONARY TUBERCULOSIS</u> INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION <u>2/11/52</u>		19b. MAJOR FINDINGS OF OPERATION <u>TUBERCULOUS ABSCESS RIGHT UPPER LOBE</u>	
20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		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)	
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 <u>1-31-52</u> , 19 <u> </u> , to <u>2-21-52</u> , 19 <u> </u> , that I last saw the deceased <u>alive on 2-21-52</u> and that death occurred at <u>3:35 Pm.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>Milton H. Lewis</u> (Degree or title) <u>M.D.</u>		23b. ADDRESS <u>VAH JEFF BRKS, MO.</u>	
23c. DATE SIGNED <u>2-21-52</u>		24. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
24b. DATE <u>2-25-52</u>		24c. NAME OF CEMETERY OR CREMATORY <u>NATIONAL CEMETERY</u>	
24d. LOCATION (City, town, or county) (State) <u>JEFFERSON BARRACKS, MO.</u>		DATE REC'D BY LOCAL REG. <u>2-23-52</u>	
REGISTRAR'S SIGNATURE <u>Harbert R. Danke M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>SUEMEYER & SON'S</u> ADDRESS <u>3934 N. 20th. Street</u>	

JUL 17 1967

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

Arthur W. Dutschke

Licensed Embalmer No. *4329*

P. O. Address *St. Louis, Mo.*

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.