

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). a. STATE Missouri b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) Mo.		c. LENGTH OF STAY (In this place) Mo. 12 days	c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Chronia Hosp			e. STREET ADDRESS (If rural, give location) 22 1902 Hickory St. 2229		
3. NAME OF DECEASED (Type or Print) Laura		a. (First)	b. (Middle)	c. (Last) Arenz	4. DATE OF DEATH (Month) (Day) (Year) May 28, 1954
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widow		8. DATE OF BIRTH April 3, 1877	9. AGE (In years last birthday) 77 if UNDER 1 YEAR Months Days if UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Virginia	12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME Reuben Southern		13b. MOTHER'S MAIDEN NAME Wealthy ????		14. NAME OF HUSBAND OR WIFE George Arenz	
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 Chronic Hospital Records		

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, ashenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized Arteriosclerosis ANTECEDENT CAUSES with Heart and Brain Damage. Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			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)		
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? 4500		

22. I hereby certify that I attended the deceased from October 16, 53 to May 28, 1954, that I last saw the deceased alive on May 28, 1954, and that death occurred at 11:50 A., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Palmer Minnie Bowditch M.D.		23b. ADDRESS 5800 Arsenal St.		23c. DATE SIGNED 5-28-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 5-29-54	24c. NAME OF CEMETERY OR CREMATORY Crystal City	24d. LOCATION (City, town, or county) (State) Mo	
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DATE REC'D BY LOCAL REG. JUN 1 1954		REGISTRAR'S SIGNATURE J. Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Politte Funeral Home Crystal City Mo		
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WRITE PLAINLY--USING UNFAADING 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.....
Signature of Student Embalmer

Signed.....
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.