

FILED JUL 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24219**
6467

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

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (When deceased lived. If institution: residence before admission). a. STATE Missouri		b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. LENGTH OF STAY (If this place) 36 hours		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Firmin Desloge Hospital		e. STREET ADDRESS (If rural, give location) 23 2510 Shenandoah		4. Is Residence within limits of a city (unincorporated town)? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or Print) a. (First) Charles			b. (Middle) _____			c. (Last) ARNALL			4. DATE OF DEATH (Month) (Day) (Year) July 14, 1954		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED Widowed		8. DATE OF BIRTH Aug. 27, 1887		9. AGE (In years, last birthday) 77		9. AGE (In years, Months, Days, Hours, Min.)	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10. KIND OF BUSINESS OR INDUSTRY Carpenter		11. BIRTHPLACE (City and State or Foreign Country) Wright City, Mo.			12. CITIZEN OF WHAT COUNTRY? USA		

13a. FATHER'S NAME William Arnall			13b. MOTHER'S MAIDEN NAME Elizabeth Reed			14. NAME OF HUSBAND OR WIFE Deceased.		
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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) No		16. SOCIAL SECURITY NO. Yes, Unk.		17. INFORMANT'S SIGNATURE OR NAME Elizabeth Gustavison, 3510 Shenandoah				ADDRESS	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>This does not mean the immediate cause, such as myocardial infarction, pneumonia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ideal Stroke		ANTECEDENT CAUSES Mortal conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive Cardiovascular Dis. DUE TO (c) Acute infarction of Left Kidney							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Marked systemic sclerosis									

18a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION (OK P.F.T.)						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, etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) 443X-F		(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? 50247					

22. I hereby certify that I attended the deceased from **7/13/54, 19** to **7/14/54, 19**, that I last saw the deceased alive on **7/14/54, 19**, and that death occurred at **5:42P. M.**, from the causes and on the date stated above.

23a. SIGNATURE Robert H. Ramsey, M.D.			23b. ADDRESS Firmin Desloge Hospital			23c. DATE SIGNED 7/14/54		
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 7-15-54		24c. NAME OF CEMETERY OR CREMATORY Rose Hill		24d. LOCATION (City, town, or county) (State) Breckenridge, Mo.			
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DATE REC'D BY LOCAL REG. JUL 15 1954		REGISTRAR'S SIGNATURE J. Carl Smith, M.D.			25. FUNERAL DIRECTOR'S SIGNATURE McLaughlin, 2301 Lafayette, St. Louis, Mo.					ADDRESS	
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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.....
Signature of Student Embalmer

Signed..... *James R. Chapman*

Licensed Embalmer No. *45*

P. O. Address *St. Louis*

**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.**