

STANDARD CERTIFICATE OF DEATH

State File No. **31608**
Registrar's No. **7890**

FILED SEP 16 1954

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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) TOWN Saint Louis, Missouri		c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> 9
c. LENGTH OF STAY (in this place)		e. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1		25 523 Market Street 225/10	
3. NAME OF DECEASED a. (First) William b. (Middle) Arnold c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) 8-1-54
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 4-27-84
9. AGE (In years last birthday) 70		IF UNDER 1 YEAR Months: Days:	IF UNDER 6 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 none	11. BIRTHPLACE (City and State or Foreign Country) Unknown
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME John	
13b. MOTHER'S MAIDEN NAME Elizabeth		14. NAME OF HUSBAND OR WIFE unknown	
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.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Hospital Records 1515 Lafayette
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Pyelonephritis, Chronic DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pneumonia	
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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 6000	
22. I hereby certify that I attended the deceased from 7-26 , 19 54 , to 8-1 , 19 54 , that I last saw the deceased alive on 8-1 , 19 54 , and that death occurred at 9:30P m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) C. J. Sherkins M.D.		23b. ADDRESS 1515 Lafayette A-e.	23c. DATE SIGNED 8-2-54
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 8-31-54	24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
DATE REC'D BY LOCAL REG. AUG 26 1954	REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rowland-Aker Mortuary Service	

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.