

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14205**

FILED APR 27 1955

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **347** Registrar's No. **874**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Mo b. COUNTY St. Louis	
b. CITY OR TOWN Richmond Heights	c. LENGTH OF STAY (in this place) 3 weeks	c. CITY (If outside corporate limits, write RURAL and give township) Ferguson 1090	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Hospital		d. STREET ADDRESS (If rural, give location) 413 Coppinger Drive	

3. NAME OF DECEASED (Type or Print)		a. (First) Mary	b. (Middle) Ann	c. (Last) Arman	4. DATE OF DEATH (Month) (Day) (Year) 4-14-1955		
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married		8. DATE OF BIRTH 3-16-1949	9. AGE (In years last birthday) 6	IF UNDER 1 YEAR Months Days	IF UNDER 1 YEAR Hours Mins
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) St. Louis Mo		12. CITIZEN OF WHAT COUNTRY U.S.	

13a. FATHER'S NAME Paul Arman	13b. MOTHER'S MAIDEN NAME Christina Miller	14. NAME OF HUSBAND OR WIFE None
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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. None	17. INFORMANT'S SIGNATURE OR NAME Paul Arman - 413 Coppinger Dr	ADDRESS
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		19. INTERVAL BETWEEN ONSET AND DEATH 4 years
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Mucoviscidosis (Pulmonary)		
	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	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 5272
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

22. I hereby certify that I attended the deceased from _____, 1903, to 4-14, 1955, that I last saw the deceased alive on 4-14, 1955, and that death occurred at 5 P m., from the causes and on the date stated above.

23a. SIGNATURE Chung Li	(Degree or title)	23b. ADDRESS 6420 Clayton	23c. DATE SIGNED 4-15-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4-16-55	24c. NAME OF CEMETERY OR CREMATORY Lake Charles Cem	24d. LOCATION (City, town, or county) (State) St. Louis County Mo
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DATE REC'D BY LOCAL REG. 4/15/55	REGISTRAR'S SIGNATURE Herbert Kolomb	25. FUNERAL DIRECTOR'S SIGNATURE Chas Koch	ADDRESS 2116 N. 14th
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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
Student Embalmer

Signed Bill C. Hanson

Licensed Embalmer No. 4764

P. O. Address St. Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.