

FILED DEC 3 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **39111**

|  |                               |  |  |   |   |  |   |
|--|-------------------------------|--|--|---|---|--|---|
| BIRTH NO. _____  |                               | REG. DIST. NO. <b>310</b>  |  | PRIMARY REG. DIST. NO. <b>3058</b>  |   | Registrar's No. <b>8</b>   |   |
| 1. PLACE OF DEATH<br>a. COUNTY <b>ST. CHARLES</b>  |                               |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>MO</b> b. COUNTY <b>ST. CHARLES</b> |   |  |   |
| b. CITY OR TOWN <b>ST. CHARLES</b>   |                               | c. LENGTH OF STAY (in this place) <b>3 DAYS</b>  |  | c. CITY OR TOWN <b>ST. CHARLES</b>  |   | d. STREET ADDRESS (If rural, give location) <b>R. F. II # 2</b>                  |   |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. JOSEPH HOSPITAL</b>   |                               |  |  | d. STREET ADDRESS (If rural, give location) <b>R. F. II # 2</b>   |   |  |   |
| 3. NAME OF DECEASED<br>a. (First) <b>EMMA</b>  |                               |  | b. (Middle) <b>C.</b>  |   | c. (Last) <b>ARRAS</b>  |  | 4. DATE OF DEATH (Month) (Day) (Year) <b>NOV. 27-1956</b> |
| 5. SEX <b>FEMALE</b>   | 6. COLOR OR RACE <b>WHITE</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)                                   | 8. DATE OF BIRTH <b>JAN. 19-1881</b>                                 |   | 9. AGE (In years last birthday) <b>75</b>                           | IF UNDER 1 YEAR Days   | IF UNDER 24 HRS. Hours   Min.                             |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WORK</b>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country) <b>ST. CHARLES Co. MO.</b>  |   | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |   |
| 13a. FATHER'S NAME <b>ANDREW MILLER</b>  |                               |  | 13b. MOTHER'S MAIDEN NAME <b>GUTER MUTH</b>                          |   | 14. NAME OF HUSBAND OR WIFE <b>JAMES A. ARRAS</b>                   |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>   |                               | 16. SOCIAL SECURITY NO. <b>NO SE</b>   | 17. INFORMANT'S SIGNATURE OR NAME <b>James A. Arras. St. Charles</b> |   |   |  |   |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Thrombosis</b>                                |   |  | INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>            |
| ANTECEDENT CAUSES<br>Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.   |                               |  |  | DUE TO (b) <b>Atherosclerosis</b>   |   |  |   |
| DUE TO (c)   |                               |  |  | II. OTHER SIGNIFICANT CONDITIONS<br>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"/> |   |
| 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?   |  |   |   |  |   |
| 22. I hereby certify that I attended the deceased from <b>Nov. 25, 1956</b> , to <b>Nov. 27, 1956</b> , that I last saw the deceased alive on <b>Nov. 25, 1956</b> , and that death occurred at <b>1:00 P.M.</b> , from the causes and on the date stated above. |                               |  |  |   |   |  |   |
| 23a. SIGNATURE <b>James J. Conroy</b> (Degree or title) <b>M.D.</b>  |                               |  |  | 23b. ADDRESS <b>St. Charles Mo</b>  |   | 23c. DATE SIGNED <b>Nov 30 1956</b>  |   |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                               | 24b. DATE <b>NOV. 30-'56</b>   | 24c. NAME OF CEMETERY OR CREMATORY <b>ST. JOHN'S E+R</b>             |   | 24d. LOCATION (City, town, or county) (State) <b>ST. CHARLES MO</b> |  |   |
| DATE REC'D BY LOCAL REG. <b>Nov 30 1956</b>  |                               | REGISTRAR'S SIGNATURE <b>Francis Hamilton</b>  |  | 25. FUNERAL DIRECTOR'S SIGNATURE <b>Ch. Kelly</b>   |   | ADDRESS <b>O'FALLON MO</b>   |   |

(Licensed Embalmer's Statement on Reverse Side)

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 \_\_\_\_\_

*E. A. Keith*

Licensed Embalmer No. *822*

P. O. Address *O'Fallon*

**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.