FILED JUN 14 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18409
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5305

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St.Louis — Inside Limits Yes X No ☐	c. CITY OR TOWN St.Louis — Inside Limits Yes X No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St.Luke's Hospital — Length of stay in lb. 32 h-mon.	d. STREET ADDRESS (If outside, give location) 3304 Russell Blvd. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print)	First: Lily	Middle: Ann	Last: Arzt
4. DATE OF DEATH	Month: June	Day: 5	Year: 1957
5. SEX: F.	6. COLOR OR RACE: W.	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: March 30,1899
9. AGE (In years last birthday): 58	IF UNDER 1 YEAR: Months 3 Days 5	IF UNDER 24 HRS.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Teacher	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country): St.Louis,Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Franz Arzt		14. MOTHER'S MAIDEN NAME: Katherine Hais	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address: Dr.Franz Arzt,3304 Russell Blvd.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) acute myelogenous leukaemia — INTERVAL BETWEEN ONSET AND DEATH: May, 1957

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ____ DUE TO (c) ____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 2041

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from May 3, 1957, to June 5, 1957 and last saw her alive on June 5, 1957
Death occurred at 9:50 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Wm G Becke M.D.	22b. ADDRESS: 3720 Washington	22c. DATE SIGNED: 6-6-57

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: June 8,1957	23c. NAME OF CEMETERY OR CREMATORY: Bellefontaine Cemetery	23d. LOCATION (City, town, or county) (State): St.Louis,Missouri
24. FUNERAL DIRECTOR: Arthur J Donnelly	ADDRESS: 3840 Lindell Blvd.	25. DATE RECD. BY LOCAL REG.: JUN 6 '57	26. REGISTRAR'S SIGNATURE: J Earl Smith MD MDB.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e

by ~~me, or by~~ me ....., Student Embalmer No.....

working under my personal supervision.

Student.....
Signature of Student Embalmer

Signed W. T. Salgen

Licensed Embalmer No. 46

P. O. Address 384 Kim

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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.