

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUL 5 1957

STATE FILE NUMBER 223254841
Registrar's No. 1003

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION City Hospital #1		Length of stay in lb 1 hr.	STREET ADDRESS 4234 Chouteau ave.		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MIDDLE Last HENRY M. ARAND			4. DATE OF DEATH Month Day Year 5-22-57		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-3-1886	9. AGE (In years last birthday) 70 IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired watchman		10b. KIND OF BUSINESS OR INDUSTRY Packing Co.	11. BIRTHPLACE (City and state or country) Union, Mo.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Gustav Arand			14. MOTHER'S MAIDEN NAME Mary Louise		
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. 489-07-0998	17. INFORMANT Address Victoria Arand, 4234 Chouteau ave.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Myocarditis</i> DUE TO (b) <i>Generalized Arterio Sclerosis</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 422.1			
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 _____ to _____ and last saw her alive on _____ Death occurred at <i>429 A</i> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>James M. Kelly Deputy</i>			22b. ADDRESS <i>1300 Clark</i>		22c. DATE SIGNED <i>5-23-57</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE <i>5-23-57</i>	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) <i>Washington, Mo.</i>
24. FUNERAL DIRECTOR ADDRESS <i>Rowland-Aker, 4104 Manchester</i>			25. DATE RECD. BY LOCAL REG. <i>MAY 23 '57</i>		26. REGISTRAR'S SIGNATURE <i>J. Carl Smith</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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diseases in Part I, must be causally related. Coroner cannot certify to a death due to natural causes.

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 *W E Morris*.....

Licensed Embalmer No. *3*.....

P. O. Address *St Louis*.....

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.