

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-025366

FILED VS. JUN 20 1960 317

Primary Registration District No. 500

Registrar's No. 1799

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY St. Louis				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY ST Louis					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN LE MAY		Length of stay in 1b 24 hours		c. CITY OR TOWN Country Club Hills		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mt. St. Rose Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 5630 Gatesworth		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last JEAN E ARNOLD				4. DATE OF DEATH Month Day Year June 8 1960					
5. SEX female	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 10/10/1914	9. AGE (last birthday) 45 years	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work			10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (City and state or country) Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME John Wanner			13b. MOTHER'S MAIDEN NAME Blanche Gregir			14. NAME OF HUSBAND OR WIFE Leon E. Arnold			
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 Address Leon Arnold - 5630 Gatesworth					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure							INTERVAL BETWEEN ONSET AND DEATH 5 days		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cor Pulmonale							1 year		
DUE TO (c) Pulmonary Fibrosis							10 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO/DEATH but not related to the terminal disease condition given in PART I (a) For. Adv. Pulmonary Hc, Inactive 10 yrs						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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.)							
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		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 August, 1950 to June 8, 1960 and last saw her alive on June 8, 1960 . Death occurred at Mt. St. Rose Hosp. 3:45 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) Masas Arnold M.D.				22b. ADDRESS 607 N. Grand (3)			22c. DATE SIGNED 6/10/60 (State)		
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE June 11, 1960	23c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory		23d. LOCATION (City, town, or county) St. Louis County Missouri				
24. FUNERAL DIRECTOR ADDRESS BUCHHOLZ MORTUARY - 5967 W. Florissant			25. DATE RECD. BY LOCAL REG. 6-10-60		26. REGISTRAR'S SIGNATURE [Signature]				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
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 conform 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.