

**MISSOURI STATE BOARD OF HEALTH**  
**BUREAU OF VITAL STATISTICS**  
**CERTIFICATE OF DEATH** 399

Do not use this space.

19526

**1. PLACE OF DEATH**

County Jackson Registration District No. 1002  
 Township Ward Primary Registration District No. \_\_\_\_\_  
 City St. Louis City No. 409 Indiana St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
 Registered No. 2525 St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. 409 Indiana St. 9 Ward \_\_\_\_\_  
 (Usual place of abode) (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX 7 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 5, 1866

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
64 | 2 | 12 | \_\_\_\_\_

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work. at home  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) Arkansas

**10. NAME OF FATHER**

John A. Arrington

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY) Arkansas

**12. MAIDEN NAME OF MOTHER**

Georgia Anna Green

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY) Arkansas

**14. INFORMANT**

(Address) Albert B. Grammel  
409 Indiana

**15. FILED**

6/17/30 M. M. Crowe  
 asst. REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 17 1930

17. I HEREBY CERTIFY, That I attended deceased from June 15, 1930, until June 17, 1930, that I last saw him alive on June 16, 1930, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Acute endocarditis

(duration) 3 yrs. 3 mos. 13 ds.  
1911

**CONTRIBUTORY (SECONDARY)**

hypertension, chronic  
 (duration) 2 yrs. 2 mos. 12 ds.

**18. WHERE WAS DISEASE CONTRASTED**

at her home

**19. DID AN OPERATION PRECEDE DEATH? DATE OF \_\_\_\_\_**

**20. WAS THERE AN AUTOPSY? \_\_\_\_\_**

**WHAT TEST CONFIRMED DIAGNOSIS?**

(Signed) W. W. [Signature] M. D.  
 (Address) 715 Argyle Bldg

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL**

Forest Hill DATE OF BURIAL 6/19/30

**20. UNDERTAKER**

D. H. Newcomer ADDRESS Southeast 169

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

U.S. 1/10

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