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.

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

Do not use this space.

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. 21387

Township ..... Primary Registration District No. 1002 Registered No. 5171

City St Louis (No. ....., City Hospital St. ..... Ward)

2. FULL NAME John T. Arnold

(a) Residence, No. 4956 Rosalie St., 9 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*): married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF ~~(OR) WIFE OF~~ Martha (Smith) Arnold

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 5-1852

7. AGE: YEARS 81 MONTHS 0 DAYS 5 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Laborer Bricklayer
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Retired
10. Date deceased last worked at this occupation (month and year) .....
11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn.

FATHER

13. NAME Shelton Arnold
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER

15. MAIDEN NAME Unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) [illegible] 4956 Rosalie Ave

18. BURIAL, CREMATION, OR REMOVAL
PLACE St Peters DATE June 14, 1933

19. UNDERTAKER (ADDRESS) Bramschuig Und Co 4740 W. Florissant Ave

20. FILED ....., 19.... J. F. Bredeck Registrar. 6/13/33

MEDICAL CERTIFICATE OF DEATH

No physician in attendance

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 12, 1933

22. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19....

I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at 5:07 P.m.

The principal cause of death and related causes of importance were as follows:

Contusions & Lacerations of brain
Fracture of all ribs both sides
Haemorrhage of both Pleural cavities
Fractured left arm & bruised right arm

Date of onset

Other contributory causes of importance:
How deceased received injuries could not be ascertained.

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19.....

Where did injury occur? ..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) Harold R. [illegible], M.D.

(Address) Deputy Coroner