

REC'D FEB 14 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 4207

Registration District No. 784

Primary Registration District No. 101

Registrar's No. 2503

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Clayton

(c) Name of hospital or institution: St. Louis County Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 19 days
(Specify whether life: _____ years, months or days)

3. (a) PRINT FULL NAME Hester, Arthur Ronald

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex male

5. Color or race colored

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Nov. 21 1940
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>0</u>	<u>0</u>	<u>19</u>	hr. _____ min.

9. Birthplace Clayton Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation nil.

11. Industry or business _____

MOTHER FATHER {

12. Name Unknown Unknown

13. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Bernice Hester

15. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant St. Louis Co. Hospital

(b) Address Clayton, Mo.

17. (a) Cremation
(Burial, cremation, or removal)

(b) Date thereof 1-24-41
(Month) (Day) (Year)

(c) Place: burial or cremation City of St. Louis

18. (a) Signature of funeral director St. Louis Co. Hosp.

(b) Address Clayton, Mo.

19. (a) JAN 24 1941
(Date received local registrar)

(b) DR. M. J. ...
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

(c) City or town S. Kinloch
(If outside city or town limits, write "RURAL")

(d) Street No. Jackson and Scudder
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 10
year 1940 hour 6 minute 15 P. M.

21. I hereby certify that I attended the deceased from 11-21-40
_____ 19____, to 12-10-40 19____;
_____ im alive on 12-10-40 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Primal injury
Malnutrition

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

Duration 19 days

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature James David M. D. (M. D. or other) ⓪

Address St. Louis Co. Hosp. Date signed 12/11/40

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

..... Licensed Embalmer No.....

..... P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.