

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

7988+

State File No. _____

FILED MAR 19 1941

Registration District No. 257

Primary Registration District No. 3036

Registrar's No. 44

1. PLACE OF DEATH:

(a) County St. Charles
(b) City or town St. Charles
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Joseph Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 min.
(Specify whether
In this community Life Time
years, months or days)

3. (a) PRINT FULL NAME Anna Arnold

3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Cornelius Arnold 6. (c) Age of husband or wife if alive 1881
7. Birth date of deceased Feb. 26 1941
(Month) (Day) (Year)

8. AGE: Years 60 Months 0 Days 2 If less than one day hr. min.

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

10. Usual occupation At home

11. Industry or business

12. Name Unold Sanders
13. Birthplace Germany 4
(City, town, or county) (State or foreign country)
14. Maiden name Mary Palmer
15. Birthplace Germany 4
(City, town, or county) (State or foreign country)

16. (a) Informant Sister Gaudencia

(b) Address St. Joseph Hospital 3. Chaffin

17. (a) Burial (b) Date thereof March 3/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Uli Saints Cem. St. Peters Mo.

18. (a) Signature of funeral director W. Le. Delmeyer

(b) Address St. Charles Mo

19. (a) 3-1-41 (b) Clarence D. Neesler
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Charles
(c) City or town St. Peters
(If outside city or town limits, write "RURAL")
(d) Street No. 1
(If rural, give location)
(e) If foreign born, how long in U. S. A. 1 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 28
year 1941 hour 7 minute 30 P. M.

21. I hereby certify that I attended the deceased from Coroner's Verdict
that I last saw him alive on 19
and that death occurred on the date and hour stated above.

Immediate cause of death Fracture of skull

Due to multiple fractures

Due to of bones of body

Other conditions (Include pregnancy within 3 months of death)

Major findings: none
Of operations none

Of autopsy none

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

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

(b) Date of occurrence Feb 28 1941

(c) Where did injury occur? St. Peters (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Highway #40

(Specify type of place)

While at work? no (e) Means of injury Automobile

23. Signature Dr. Erich Schuch (M. D. or other)

Address St. Charles Mo. Date signed 3/1/41

Duration

One hour
death

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

17008
98

7-2-41

Highway Dept. report -
Pedestrian struck by auto.

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 John E. Hallmeyer

Licensed Embalmer No. 295-1

P. O. Address St Charles Mo

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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 7988

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 757

Primary Registration District No. 3036

Registrar's No.

1. PLACE OF DEATH:

(a) County St Charles
(b) City or town St Charles
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether)
In this community years, months or days

3. (a) PRINT FULL NAME Anna Arnold

3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife 6. (c) Age of husband, or wife, if alive 1881 year

7. Birth date of deceased Feb 26 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day min.
60 0 2

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

10. Usual occupation

11. Industry or business

12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant (b) Address

17. (a) (b) Date thereof (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director (b) Address

19. (a) May 5-1941 (b) Clovene S. Mosley (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(c) City or town (If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A. ? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Feb day 28 year 1941 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19 that a last saw h alive on and that death occurred on the date and hour stated above. Immediate cause of death.

Due to
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

Duration

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) (c) Means of injury

23. Signature G. P. Erick Shultz (M. D. or other) Address St Charles Mo Date signed

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

SUPPLEMENTARY

