

FILED APR 1 1944  
Registration District No. 318

Primary Registration District No. ....

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

1. PLACE OF DEATH:  
(a) County.....  
(b) City or town..... St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Louis City Hospital  
(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 Arthur E. Hope  
3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced, Widower  
6. (b) Name of husband or wife Luete Hope 6. (c) Age of husband or wife if alive years  
7. Birth date of deceased September 1 1879  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
64 6 20 hr. min.

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

10. Usual occupation Retired Painter

11. Industry or business

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

16. (a) Informant Mrs. Arthur D. Hope

(b) Address 1326a Shenandoah

17. (a) Burial (b) Date thereof 3-25-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) MAR 24 1944 (b) J. F. Bredech  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 000  
(a) State Missouri (b) County 17  
(c) City or town St. Louis 912  
(If outside city or town limits, write "RURAL")  
(d) Street No. 729 Aubert  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country..... 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 21  
year 1944 hour 7:05 minute P. M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....;  
that I last saw him..... alive on....., 19.....;  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Apoplexy  
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)..... (e) Means of injury.....

23. Signature James J. Fifer (M.D. or other) 13  
Address 1326a Shenandoah Date signed 3/24/44

**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 Agnoscchi*  
.....

Licensed Embalmer No. *2398*

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.**