

FILED OCT 23 1944
 818

State File No. _____
 Registrar's No. 8812

Registration District No. _____ Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Little Sisters of the Poor
3225 N. Florissant
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution Two Years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Peter John Von Arb

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex Male 5. Color or race white 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 Sept. 23, 1875
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	69	0	21	hr. _____ min.

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

10. Usual occupation Laborer

11. Industry or business _____

MOTHER FATHER

12. Name Dominic Von Arb

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

14. Maiden name Madelaine Steinmetz

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

16. (a) Informant Little Sisters of the Poor

(b) Address 3225 N. Florissant

17. (a) Burial (b) Date thereof Oct. 18, 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Bromschwig Und. Co.

(b) Address 4746 West Florissant

19. (a) OCT 17 1944 (b) J. F. Bredaek
(Date received local registry) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St. Louis
(If outside city or town limits, write "RURAL")
 (d) Street No. 3225 N. Florissant Ave
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 14
 year 1944 hour 9 minute 30 P. M.

21. I hereby certify that I attended the deceased from Oct. 7, 1944, to Oct. 14, 1944
 that I last saw him alive on Oct. 14, 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death Acute Distention of the Heart
 Due to Chronic Myocarditis

Other conditions None
(Include pregnancy within 3 months of death)

Major findings: Of operations None
 Of autopsy None

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

(a) Accident, suicide, or homicide (specify) None
 (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)
(a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z)

23. Signature Bernard K. Holtz (M. D. or other)
 Address 2312 Salisbury Date signed 10-16-44

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Duration 14 hours
 PHYSICIAN
 Underline the cause to which death should be charged statistically.

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

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 Sy W Wilkinson
Licensed Embalmer No 35-175

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.