

No. 2  
5-43  
-17-39  
X38671

**FILED FEB 16 1945 318**

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County **St. Louis, Mo.**

(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: **St. Louis City Hospital - Max C. Starkloff**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **13 days Memorial**  
(Specify whether years, months or days)

In this community **52 Yrs. 2 Mons 16 Days**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **17**

(c) City or town **St. Louis** (If outside city or town limits, write "RURAL")  
Street No. **1713 N 9th St** (If rural, give location)

(e) Citizen of foreign country? **0** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Arthur Wors**

3. (b) If veteran, name war **War No 1**

3. (c) Social Security No. \_\_\_\_\_

4. Sex **Male** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Ruth Funnel**

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

7. Birth date of deceased **11 17 1892**  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb.** day **3rd**  
year **1945** hour **2:05** minute **A.** M.

21. I hereby certify that I attended the deceased from **1/21/45**  
\_\_\_\_\_, 19\_\_\_\_, to **2/3/45**, 19\_\_\_\_;  
that I last saw him alive on **2/3/45**, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<b>52</b>	<b>2</b>	<b>16</b>	_____ hr. _____ min.

Immediate cause of death **amoebic Dysentery**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) **27**

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

10. Usual occupation **Com Laborer**

PHYSICIAN

Major findings:  
Of operations \_\_\_\_\_

Of autopsy **Refused**

Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business \_\_\_\_\_

12. Name **Charles W Wors**

13. Birthplace **London England**  
(City, town, or county) (State or foreign country)

14. Maiden name **Ellen Griggs**

15. Birthplace **Washburn Ill**  
(City, town, or county) (State or foreign country)

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? \_\_\_\_\_

16. (a) Informant **James Wores**

(b) Address **704 Yale Ave Webster Grove**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **2 6 45**  
(Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park**

18. (a) Signature of funeral director **Douchant & Goodhart**

(b) Address **2228 St. Louis Ave**

19. (a) **FEB 5 1945** (Date received local registrar) (b) **J. F. Bredek** (Registrar's signature)

23. Signature **Herbert C. Fritz** (M. D. or other) \_\_\_\_\_  
Address **1515 Lafayette** (Specify type of place) (c) Means of injury **2/3/45** signed \_\_\_\_\_

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

10  
7  
9

**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  
.....  
.....  
working under my personal supervision.

Signed *Charles Goodrich*  
.....  
Registered Apprentice No. ....  
Licensed Embalmer No. *2777*  
.....  
P. O. Address *Lower Md*  
.....

**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.**