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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 23 1945

Registration District No. 377

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 14508

Primary Registration District No. 6076

Registrar's No. 277

1. PLACE OF DEATH:

(a) County St. Louis County

(b) City or town Jefferson Barracks, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Veterans Administration Facility
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Adm.Mar.24, 1945 (Specify whether
In this community -
years, months or days)

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. 4542 Lexington St.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Charles H. Arning

3. (b) If veteran, name war WW - 1

3. (c) Social Security No. 493-07-3498

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Oct. (Month) 10 (Day) 1879 (Year)

8. AGE: Years 65 Months 5 Days 15 If less than one day hr. min.

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

10. Usual occupation Tavern Proprietor

11. Industry or business -

MOTHER FATHER

12. Name Charles Arning

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

14. Maiden name Katherine Knollman

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

16. (a) Informant Clinical Records

(b) Address Vet.Adm.Fac., Jefferson Brks,Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar.28,1945. (Month) (Day) (Year)

(c) Place: burial or cremation National Cem.Jefferson Barracks, Mo.

18. (a) Signature of funeral director Calvin F.Feutz

(b) Address 4828 Natural Bridge Blvd.

19. (a) MAR 28 1945 (Date received local registrar) (b) Dr C G McGavran (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 25 year 1945 hour 9:00 minute P.M.

21. I hereby certify that I attended the deceased from March 24, 1945 to March 25, 1945; that I last saw him alive on March 25, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

Coronary arteriosclerotic heart disease with myocardial damage and ~~Due to~~ insufficiency. — Unknown

~~Due to~~ -

Other conditions Arteriosclerosis generalized. Unknown
(Include pregnancy within 3 months of death)

Major findings:
Of operations -

Of autopsy - No autopsy.

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) No

(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? (Specify type of place)

While at work? (e) Means of injury -

23. Signature E.V.EDWARDS, MAJOR,M.C. (M. D. or other)

Address Clinical Director. Date signed 3/26/45

(Licensed Embalmer's Statement on Reverse Side)

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 A. Mlenar

Licensed Embalmer No. 4186

P. O. Address St. Louis 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, fact should be so stated above.