

S. No. 2  
FORM-2-43  
Rev. 5-17-39  
I X35957

18523

#38962  
DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 5438 ✓

FILED JUN 30 1945  
318

1000

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

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 #1.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. 16 days  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County 000

(c) City or town ST LOUIS  
(If outside city or town limits, write "RURAL")

(d) Street No. 3225 MONTA ROMERY  
(If rural, give location)

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

3. (a) PRINT FULL NAME John Arent

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

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 (Day) (Year)

7. Birth date of deceased NOV 1865  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 21st  
year 1945 hour 12:10 minute P. M.

21. I hereby certify that I attended the deceased from 6/5/45  
\_\_\_\_\_ 19, to 6/21/45 19, \_\_\_\_\_  
that I last saw him alive on 6/21/45 19, \_\_\_\_\_  
and that death occurred on the date and hour stated above.

8. AGE: abt. 79 Years Months Days If less than one day  
hr. min.

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

10. Usual occupation LABOR

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

MOTHER FATHER

12. Name U. A.

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

14. Maiden name U. A. 9

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

16. (a) Informant Monte LePaul  
(b) Address 2835 Mullough

17. (a) BURIAL (b) Date thereof JUNE 22 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director Walter Kelly  
(b) Address 4386 Lindell

19. (a) JUN 22 1945 (b) J. F. Beede  
(Date received local registrar) (Registrar's signature)

Immediate cause of death Arterio Sclerotic Heart Disease

Due to Myocardial Right leg

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

Other conditions (include pregnancy within 3 months of death) 93

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

Of autopsy \_\_\_\_\_

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 Caron Hendrix 6/21/45  
(M. D. or dentist) (Date signed)

Address 1515 Lafayette

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

0 44  
11/10/2 725  
X 2222 2222

5177.8 511111

1121 1011

122171

**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.

*Not embalmed*

Signed.....

Licensed Embalmer No.....

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.**