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ev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28825

FILED SEP 21 1945

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7924

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: Alx Bros Hosp 0
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County N.R. 50
(c) City or town Jefferson County
(If outside city or town limits, write "RURAL")
Arnold Mo
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Walter G Arnold
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Male
5. Color or race W
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 Jan (Month) 7 (Day) 1917 (Year)
8. AGE: Years 28 Months 8 Days 1 If less than one day hr. min.
9. Birthplace Mo. (City, town, or county) 0 (State or foreign country)
10. Usual occupation Maintaince
11. Industry or business Amr.Car Foundry
FATHER 12. Name Frank Arnold
13. Birthplace Mo. (City, town, or county) 0 (State or foreign country)
MOTHER 14. Maiden name Louis Westman
15. Birthplace Mo. (City, town, or county) 0 (State or foreign country)
16. (a) Informant Isidore Arnold
(b) Address Arnold Mo.
17. (a) (Burial, cremation, or removal) (b) Date thereof 9/11/45 (Month) (Day) (Year)
(c) Place: burial or cremation Maxville Mo.
18. (a) Signature of funeral director Fendler Und Co
(b) Address 7420 Michigan
19. (a) SEP 10 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 8 year 1945 hour 6 minute 25 a M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhage, Fracture of skull when he fell from the [illegible] board of a [illegible] [illegible] by the [illegible] Merge New Bonn, Bath Pointe, V.V. and [illegible] Rivers Bridge St Louis Co. Mo. 4:45 A.M. August 23 1945 Duration

Due to

Due to

Other conditions Cause and manner of same (Include pregnancy within 3 months of death) Could not be determined

Major findings:
Of operations 170
Of autopsy 58

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) Accident
(b) Date of occurrence August 25 1945 about
(c) Where did injury occur? St Louis County (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 See above
23. Signature Dr Alfred J Kerry (M.D. or other)
Address Deputy Coroner Date signed 9-8-45

(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 3454

, Registered Apprentice No.

working under my personal supervision.

Signed David E. Gibson

Licensed Embalmer No. 3454

P. O. Address 1811 Princeton St

Richmond Va

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.