

Registration District No. **III 37846**

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:  
**2430 A Mo Nair Ave**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution..... (Specify whether  
In this community **Life** (Specify whether  
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. **2430 A Mo. Nair Ave**  
(If rural, give location)  
(e) Citizen of foreign country? **NO** (Yes or No)  
If yes, name country.....

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

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**  
6. (b) Name of husband or wife **Elizabeth Petri** 6. (c) Age of husband or wife if alive **70** years  
7. Birth date of deceased **July 4th 1878**  
(Month) (Day) (Year)

8. AGE: Years **67** Months **11** Days **30** If less than one day hr. min.

9. Birthplace **St Louis** (City, town, or county) (State or foreign country) **11**

10. Usual occupation **Retired**

11. Industry or business

MOTHER, FATHER { 12. Name **John Wand** 13. Birthplace **Germany** (City, town, or county) (State or foreign country) 14. Maiden name **Not Known** 15. Birthplace **Not Known** (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Elizabeth Wand** (b) Address **2430 A Mo Nair**  
17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **6-27-1946** (Month) (Day) (Year)  
(c) Place: burial or cremation **Zions Cemetery**

18. (a) Signature of funeral director **Wingbermuehle Funeral Home**  
(b) Address **3819 S. Grand Blvd**  
19. (a) **JUN 25 1946** (Date received local registrar) (b) **J. J. Bredeck** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **24th** year **1946** hour **10/15** minute **P.M.**

21. I hereby certify that I attended the deceased from **June 22** 1946 to **June 24** 1946 that I last saw him alive on **June 22** 1946 and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Myocarditis**  
**Chronic Arteriosclerosis**  
**Chronic Parenchymatous Nephritis**  
**Chronic Cystitis**  
Due to **Chronic Myocarditis**  
**Chronic Arteriosclerosis**  
**Chronic Parenchymatous Nephritis**  
**Chronic Cystitis**

Other conditions (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) **no**  
(b) Date of occurrence **no**  
(c) Where did injury occur? **none** (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) Means of injury

23. Signature **Thomas E. McJohn** (M. D. or other) **M.D.**  
Address **Methodist Hospital** Date signed **6/25/46**

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

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**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.....

*W E Morris*

Licensed Embalmer No. 3360

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.**