

FILED FEB 2 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2422

318

1003

State File No.

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, write RURAL and give OR TOWN) <u>St. Louis</u> c. LENGTH OF STAY (in this place) _____ d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Frisco Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____ c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u> d. STREET ADDRESS (If rural, give location) <u>6838 Fyler</u>			
3. NAME OF DECEASED (Type or Print) <u>William C. Arthur</u> a. (First) _____ b. (Middle) _____ c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 23 1949</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 4 1893</u>	9. AGE (In years last birthday) <u>55</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>19</u>	IF UNDER 2 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Marshfield Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>Wm F. Arthur</u>		13b. MOTHER'S MAIDEN NAME <u>Ada Charles</u>		14. NAME OF HUSBAND OR WIFE <u>Josephine</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <u>Josephine Arthur</u>				ADDRESS <u>6838 Fyler</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cirrhosis of Liver with Ascites</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>124 N 1</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 mo. 13 da</u>
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) _____		(COUNTY) _____	(STATE) _____		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____					
22. I hereby certify that I attended the deceased from <u>Nov. 17, 1949</u> to <u>Jan. 23, 1949</u> , that I last saw the deceased alive on <u>Jan 23, 1949</u> , and that death occurred at <u>3:00 AM.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Norman Miller</u>			23b. ADDRESS <u>3810-16 S. Broadway</u>		23c. DATE SIGNED <u>Jan 23, 1949</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	24b. DATE <u>Jan. 24</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn</u>	24d. LOCATION (City, town, or county) <u>Springfield</u>	(State) <u>Mo.</u>			
DATE REC'D BY LOCAL REG. <u>JAN 24 1949</u>	REGISTRAR'S SIGNATURE <u>J. B. Janssen</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Jay B. Smith</u>		ADDRESS <u>Maplewood Mo.</u>		

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

H. Burgess

Licensed Embalmer No. *4029*

P. O. Address *Maplewood*

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.