

FILED FEB 2 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2754

318

1003

State File No. 552
Registrar's No.

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		State File No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		d. STREET ADDRESS (If rural, give location) 5475 Vera Ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 5475 Vera Ave.				d. STREET ADDRESS (If rural, give location) 5475 Vera Ave.			
3. NAME OF DECEASED (Type or Print) a. (First) Adrian			b. (Middle) Guy		c. (Last) Halterman		4. DATE OF DEATH (Month) (Day) (Year) Jan. 17, 1949
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH June 20, 1875		9. AGE (In years last birthday) 73	IF UNDER 1 YEAR Months 6 Days 27	IF UNDER 4 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chemist		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) Correysville, Ohio		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME Jessie Halterman		13b. MOTHER'S MAIDEN NAME Mary Guy		14. NAME OF HUSBAND OR WIFE Elsie Halterman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes Spanish Amer.		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Elsie Halterman - 5475 Vera Ave.			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis 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. Chronic Arthritis					INTERVAL BETWEEN ONSET AND DEATH 1 yr? 3 yrs?
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) _____		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>1-5</u> , 19 <u>48</u> , to <u>1-17</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>1-17</u> , 19 <u>49</u> , and that death occurred at <u>7:30</u> A. M., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Eugene J. Arnold M.D.				23b. ADDRESS 1449 M^e Laran		23c. DATE SIGNED 1/18/49	
24a. BURIAL (CREMATION, REMOVAL) (Specify) burial		24b. DATE 1/20/49	24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cem.		24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.		
DATE REC'D BY LOCAL REG. JAN 19 1949		REGISTRAR'S SIGNATURE J. B. Leaster		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Drehmann-Harrel - 1905 Union Blvd.			

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

Dr. Eugene Arnold (1-3)
1449 McLaren

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 Warren A. Carver

Licensed Embalmer No. 3534

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.