

FILED FEB 23 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6296

State File No. 1297

318

1002

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO. 1002		Registrar's No. 1297		
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY				
b. CITY OR TOWN St Louis		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN St Louis		17		
d. FULL NAME OF HOSPITAL OR INSTITUTION 4501 Gibson				d. STREET ADDRESS (If rural, give location) 4501 Gibson.				
3. NAME OF DECEASED (Type or Print) Michael			a. (First)		b. (Middle) Arin		c. (Last)	
4. DATE OF DEATH		(Month) 2		(Day) 7		(Year) 1949		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH 10-28-1866		
9. AGE (In years last birthday) 82		IF UNDER 1 YEAR Months		IF UNDER 2 HRS. Days		IF UNDER 4 HRS. Hours		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cleaner			10b. KIND OF BUSINESS OR INDUSTRY Dry Cleaning			11. BIRTHPLACE (State or foreign country) Austria		
12. CITIZEN OF WHAT COUNTRY? USA			13a. FATHER'S NAME unknown		13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE Mary	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Mary Arin				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of the Prostate Gland		b. c.					6 yrs	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS						
19a. DATE OF OPERATION Oct 1943		19b. MAJOR FINDINGS OF OPERATION Carcinoma of the Prostate Gland					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 Dec 15, 1948, to Feb 7, 1949 that I last saw the deceased alive on Feb 7, 1949, and that death occurred at 4:30 A.M., from the causes and on the date stated above.								
23a. SIGNATURE Lindell M Kenman M.D.			23b. ADDRESS 539 N Grand St Louis, Mo			23c. DATE SIGNED 2-8-49		
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 2-7-49		24c. NAME OF CEMETERY OR CREMATORY Catholic Cemetery		24d. LOCATION (City, town, or county) (State) N. Kansas Illinois		
DATE REC'D BY LOCAL REG. FEB 10 1949		REGISTRAR'S SIGNATURE J. B. Laster		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rowland Mortuary, Inc 4104 Manchester W. Kansas, Mo				

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

1297

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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.....

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed Howard P. Rowland

Licensed Embalmer No. 311K

P. O. Address P. Lewis Mo

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.