

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41110

DEC 12 1952

50) State File No. _____

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 598 Registrar's No. 2982

400

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

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give town) <u>St. Louis, Mo</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u> 2259	
c. LENGTH OF STAY (In this place) <u>1 yr 9 mo</u>		d. STREET ADDRESS (If rural, give location) <u>Milner Hotel</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Robert Koch Hospital</u>			
3. NAME OF DECEASED a. (First) <u>FRED</u>		b. (Middle) <u>ARTHUR</u>	
c. (Last) <u>HALL</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Nov 20 1952</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED; WIDOWED, DIVORCED (Specify) <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>Jul 20 1878</u>
9. AGE (In years last birthday) <u>74</u>		10. a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOORMAN</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>HOTEL</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Iowa</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13a. FATHER'S NAME <u>William Francis Hall</u>		13b. MOTHER'S MAIDEN NAME <u>Carrie Bronson</u>	
14. NAME OF HUSBAND OR WIFE <u>None</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>492-12-1916A</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Records Robert Koch Hospital</u>		ADDRESS _____	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary Tuberculosis</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>002X</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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>Mar 23 1951</u> to <u>Nov 30 1952</u> , that I last saw the deceased alive on <u>Nov 20 1952</u> , and that death occurred at <u>4:15 pm</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>Sta. Francis</u> (Degree or title)		23b. ADDRESS <u>Robert Koch Hospital, St. Louis, Mo.</u>	
23c. DATE SIGNED <u>11-21-52</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		24b. DATE <u>11-21-52</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Crematory</u>		24d. LOCATION (City, town, or county) (State) <u>St. Charles Mo.</u>	
DATE REC'D BY LOCAL REG. <u>11-21-52</u>		REGISTRAR'S SIGNATURE <u>Herkel R. Deane-M.D.</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Alexander Son</u>		ADDRESS <u>6178 Delron</u>	

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 _____

Licensed Embalmer No. _____

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.