

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11174

FILED MAR 31 1953

State File No.

318

1003

Registrar's No. 2898

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. 2898	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE _____ b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>St. Louis</u>)		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis 2109</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>4640 Labadie</u>				d. STREET ADDRESS (If rural, give location) <u>10 4640 Labadie</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Fernan</u>			b. (Middle) <u>Arvington</u>		c. (Last) _____		4. DATE OF DEATH (Month) (Day) (Year) <u>Mar 12, 1953</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Aug 27, 1872</u>		9. AGE (In years last birthday) <u>80</u>	If UNDER 1 YEAR Months _____ Days _____	If UNDER 24 Hrs. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Ark</u>		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME <u>Sam Arvington</u>		13b. MOTHER'S MAIDEN NAME <u>Mac Anna Sibbs</u>		14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Annie B. Hendrix</u>		ADDRESS <u>4640 Labadie</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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of prostate</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.					INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>177X</u>			
22. I hereby certify that I attended the deceased from <u>Mar 12, 1953</u> , to <u>Mar 12, 1953</u> , that I last saw the deceased alive on <u>March 12, 1953</u> , and that death occurred at <u>10:30 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Edward B. Williams MD</u>			23b. ADDRESS <u>4242 Eastern St. Louis</u>			23c. DATE SIGNED <u>3-16-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Mar 17, 1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cem</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo</u>		
DATE REC'D BY LOCAL REG. <u>MAR 17 1953</u>		REGISTRAR'S SIGNATURE <u>J. Earl Smith, MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>F. C. Green</u>		ADDRESS <u>4214 Adams</u>	

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

60200

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 *F. A. Green*

Licensed Embalmer No. *2963*

P. O. Address *1314 Salway*

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.