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

FILED OCT 15 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 32835

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 9404

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4431 Blair Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis 2099
d. STREET ADDRESS (If rural, give location): 4431 Blair Ave 9 0

3. NAME OF DECEASED (Type or Print)
a. (First): John
b. (Middle): B.
c. (Last): Arens

4. DATE OF DEATH (Month) (Day) (Year): 9 - 29 - 1953

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 11-27-1875
9. AGE (In years last birthday): 77 — 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): Tin plater
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (City and State or Foreign Country): St. Louis Mo
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13a. FATHER'S NAME: Lambertus Arens
13b. MOTHER'S MAIDEN NAME: Margaret Linemann
14. NAME OF HUSBAND OR WIFE: Emma Arens
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 333-03-2937
17. INFORMANT'S SIGNATURE OR NAME: Emma Arens — ADDRESS: 4431 Blair 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, asthenia, 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) Arteriosclerosis

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

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

422

22. *I hereby certify that I attended the deceased from* Aug 20, 1953, *to* Sept 29, 19 53, *that I last saw the deceased alive on* Sept 26, 19 53, *and that death occurred at* 7 00 m., *from the causes and on the date stated above.*

23a. SIGNATURE: A. A. Hall
(Degree or title): M.D.
23b. ADDRESS: 3901 W. Florissant
23c. DATE SIGNED: 9/30/53

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-2-1953
24c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
24d. LOCATION (City, town, or county) (State): St. Louis Mo

DATE REC'D BY LOCAL REG. SEP 30 1953
REGISTRAR'S SIGNATURE: J. Carl Smith MD
25. FUNERAL DIRECTOR'S SIGNATURE: Edward Koch + Son — ADDRESS: 3516 N. 14th
MRB
(Licensed Embalmer's Statement on Reverse Side)

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 Albert Maxfield

Licensed Embalmer No. 3077

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.