

No. 300  
10.48

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

42145

FILED DEC 16 1954

State File No. \_\_\_\_\_  
Registrar's No. 10865

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		State File No. _____		Registrar's No. <u>10865</u>	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN <u>St. Louis</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Homer G. Phillips Hospital</u>				STREET ADDRESS (If rural, give location) <u>3912 Lee Ave.,</u> <u>2109</u> <u>10</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>EDWARD</u>		b. (Middle) <u>R.</u>		c. (Last) <u>ARMAN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 27th, 1954</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Feb. 25th, 1930</u>		9. AGE (In years last birthday) <u>24</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>Construction Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Mo.,</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Paul Arman</u>			13b. MOTHER'S MAIDEN NAME <u>Helen Slawski</u>			14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>469-36-2606</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Paul Arman Sr. 3912 Lee Ave.,</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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Fracture of Skull; Brain Injury; suffered in fall down stairway in tavern at 4562 No Broadway</u> 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>about 7:22 pm Nov 25 1954</u>						INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>Accident</u>						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT (Specify) <u>Accident</u>		21b. PLACE OF INJURY (e.g., in or about home, factory, street, office bldg., etc.) <u>Tavern</u>		21c. (CITY, TOWN, OR TOWNSHIP) <u>St. Louis Mo</u> (COUNTY) _____ (STATE) _____					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Nov 25 54 7:22 p.m.</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>E9006</u>					
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above. <u>6:00</u>									
23a. SIGNATURE <u>Joseph M. ...</u>				23b. ADDRESS <u>1300 Clark</u>			23c. DATE SIGNED <u>11/29/54</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Dec. 1st, 54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		24d. LOCATION (City, town, or county) <u>St. Louis, Mo.,</u> (State) _____			
DATE REC'D BY LOCAL REG. <u>NOV 29 1954</u>		REGISTRAR'S SIGNATURE <u>J. Earl Smith, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Leidner Und. Co., 2223 St. Louis Ave.,</u> ADDRESS _____					

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

S.P., (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.....  
Signature of Student Embalmer

Signed *Paul D. Wachtel*.....

Licensed Embalmer No. *478*

P. O. Address *H...*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.