

FILED DEC 11 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **39112**
Registrar's No. **15**

BIRTH NO. _____		REG. DIST. NO. 310		PRIMARY REG. DIST. NO. 3098		Registrar's No. 15	
1. PLACE OF DEATH a. COUNTY St. Charles				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY St. Charles			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Charles		c. LENGTH OF STAY (In this place) 4 d		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Cottleville		0920	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph				d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) a. (First) John		b. (Middle) -		c. (Last) Arras		4. DATE OF DEATH (Month) (Day) (Year) Nov 29 1956	
5. SEX m		6. COLOR OR RACE w		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH Nov 7-1873	
9. AGE (In years last birthday) 83		10. MONTHS 0		11. DAYS 12		12. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Cabinet maker		11. BIRTHPLACE (State or foreign country) Cottleville Mo.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME John Arras		13b. MOTHER'S MAIDEN NAME Stephans		14. NAME OF HUSBAND OR WIFE Mrs. Anna Arras			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) N		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME John H. Arras ADDRESS St. Louis Mo			
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) Cerebral Thrombosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Valvular Heart Disease DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis 421.4				INTERVAL BETWEEN ONSET AND DEATH 4 days ?	
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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov 20, 1956 , to Nov 29, 1956 , that I last saw the deceased alive on Nov 29, 1956 , and that death occurred at 9:00 P.M. , from the causes and on the date stated above.							
23a. SIGNATURE James H. Arras (Degree or title) MD				23b. ADDRESS St. Charles Mo		23c. DATE SIGNED Dec 4 1956	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE Dec 2-56		24c. NAME OF CEMETERY OR CREMATORY Mt Zion Cemetery		24d. LOCATION (City, town, or county) (State) Osage Mo	
DATE REC'D BY LOCAL REG. Dec 6 1956		REGISTRAR'S SIGNATURE Hannie Hamilton		25. FUNERAL DIRECTOR'S SIGNATURE Edna H. Hallam ADDRESS Osage Mo			

(Licensed Embalmer's Statement on Reverse Side)

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

VS MAY 24 1960

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.