

XC-1985 537

SL 14429 FILED AUG 26 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH29168
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2351

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| 1. PLACE OF DEATH a. COUNTY ST. LOUIS | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MISSOURI b. COUNTY ST. LOUIS | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN 915 N. GRAND, ST. LOUIS, MO. Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN ST. LOUIS Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) Length of stay in lb 35 HOSPITAL OR INSTITUTION VET. AIM. HOSPITAL | | d. STREET ST. FRANCIS HOTEL location) Reside on Farm ADDRESS 604 CHESTNUT Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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|--|---------------------------|---|--|--|-------------------------------------|---|
| 3. NAME OF DECEASED (Type or print) First Middle Last FRED J. ARENDES | | | 4. DATE OF DEATH Month Day Year 8-5-57 | | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4/14/97 | 9. AGE (In years last birthday) 60 | | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN | | 10b. KIND OF BUSINESS OR INDUSTRY UNKNOWN | 11. BIRTHPLACE (City and state or country) ST. LOUIS, MO. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME PAUL ARENDES | | | 14. MOTHER'S MAIDEN NAME CATHERINE BARDOL | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-1 | | 16. SOCIAL SECURITY NO. 489-05-6036 | | 17. INFORMANT Address VA HOSP. RECORDS, ST. LOUIS, MO. | | |

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| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PERFORATED DUODENAL ULCER WITH GENERALIZED PEROTENITIS. | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ | | 541.1 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHOLELITHIASIS WITH MUCOCOELE OF THE GALL BLADDER. PULMONARY EDEMA | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |

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|--|--|---|--|---|----------------------------|--|
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m. | | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | | |
| 21. I attended the deceased from 8/3/57 to 8-5-57 and last saw him ^{her} alive on 8-5-57 Death occurred at 4:10 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | |
| 22a. SIGNATURE (Degree or title) M.D. | | | 22b. ADDRESS VAH, ST. LOUIS, MO. | | 22c. DATE SIGNED 8-5-57 | |

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|--|--|---------------------|---|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE 8/8/57 | 23c. NAME OF CEMETERY OR CREMATORY National Cem/ | | 23d. LOCATION (City, town, or county) (State) Jeff Bks. Mo |
| 24. FUNERAL DIRECTOR ADDRESS Edward Fendler 5611 South Grand Blvd | | | 25. DATE RECD. BY LOCAL REG. AUG 6 57 | 26. REGISTRAR'S SIGNATURE Carl Smith MO | |

(Licensed Embalmer's Statement on Reverse Side)

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

MEDICAL CERTIFICATION

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 *Homer H. [Signature]*

Licensed Embalmer No. *30*

P. O. Address *[Signature]*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.