

FILED AUG 26 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH29171
STATE FILE NUMBERRegistration District No. **318** Primary Registration District No. **1003** Registrar **7464**

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|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | c. CITY OR TOWN Petersburg | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4106 Flad Ave. | | d. STREET ADDRESS 922 N. 5th St. | |
| 3. NAME OF DECEASED (Type or print) First Della Middle A. Last Arnold | | 4. DATE OF DEATH Month August Day 9 Year 1957 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH August 13, 1872 |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 9b. KIND OF BUSINESS OR INDUSTRY At Home | 9c. AGE (In years last birthday) 84 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | 10c. AGE (In years last birthday) |
| 11. BIRTHPLACE (City and state or country) Athens, Ill. | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME James Gilmore | | 14. MOTHER'S MAIDEN NAME Adeline Bates | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. Unknown | |
| 17. INFORMANT Homer B. Arnold, 4106 Flad Ave. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) 420.0 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" 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 g. m. p. m. | | 20d. PLACE OF INJURY (e. g., in or about home, for m., factory, street, office bldg., etc.) | |
| 20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | |
| 21. I attended the deceased from July 10, 1957 to Aug. 9, 1957 and last saw her alive on Aug. 8, 1957 Death occurred at 4:30 am on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE Joseph E. Carney M.D. (Degree or title) | | 22b. ADDRESS 906 Olive St | |
| 22c. DATE SIGNED 8-9-57 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE 8-9-57 | |
| 23c. NAME OF CEMETERY OR CREMATORY Local | | 23d. LOCATION (City, town, or county) (State) Petersburg, Ill. | |
| 24. FUNERAL DIRECTOR Albert H. Hoppe, 4700 Washington Blvd. | | 25. DATE RECD. BY LOCAL REG. AUG 9 57 | |
| 26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D. <i>SP</i> | | | |

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was

by me, or by Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *John S. [Signature]*

Licensed Embalmer No. 4

P. O. Address *St. L.*

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.