

Dr. Health,  
, & Welfare  
S. Public  
th Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-023087  
STATE FILE NUMBER

1003

FILED JUL 3 1958

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **6496**

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>House Springs</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>JEWISH HOSP</b>		Length of stay in 1b <b>4 days</b>	d. STREET ADDRESS (If outside, give location) <b>31 Rt. 2</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIS S. ARTHUR</b>			4. DATE OF DEATH Month Day Year <b>6 27 58</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/14/96</b>
9. AGE (In years last birthday) <b>62</b>		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) <b>Dist Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cooper Bessemer Corp</b>	11. BIRTHPLACE (City and state or country) <b>Astabula Ohio</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		13a. FATHER'S NAME <b>GEO. J. ARTHUR</b>	
13b. MOTHER'S MAIDEN NAME <b>MAUDE BONECKER</b>		14. NAME OF HUSBAND OR WIFE <b>GRACE (WIFE)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>NO NO</b>		16. SOCIAL SECURITY NO. <b>277-01-9229</b>	17. INFORMANT Address <b>GRACE ARTHUR House Springs Mo.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY HYPOVENTILATION</b>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>AMYOTROPHIC LATERAL SCLEROSIS</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
DUE TO (c) <b>356.1</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>SEVERE CORONARY ARTERY DISEASE (ANATOMICAL)</b>			
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 <b>9am 6/27/58</b> , to <b>11:00am 6/27/58</b> and last saw <sup>her</sup> him alive on <b>6/27/58</b> Death occurred at <b>11:00 A.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Artlan Cohn M.D.</b>		22b. ADDRESS <b>Jewish Hosp. - St. Louis</b>	22c. DATE SIGNED <b>6/27/58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>6-30-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CLAIRBORNE Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Richwood Ohio</b>
24. FUNERAL DIRECTOR <b>Brimmer Funeral Home House Springs Mo</b>		25. DATE REC'D. BY LOCAL REG. <b>JUN 28 58</b>	26. REGISTRAR'S SIGNATURE <b>J. Earl Smith M.D.</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

HSTK

REC'D (1) 1967

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 *Clarence M. Bills* .....

Licensed Embalmer No. *4325* .....  
P. O. Address *St Louis Mo* .....

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.