

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-040625

STATE FILE NUMBER

FILED DEC 15 1958

Registration District No.

179

Primary Registration District No.

5667

Registrar's No.

200

|                                                                                                                                                                                                                                                     |                               |                                                                                                                                                             |                                                                                                                   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Lincoln</b>                                                                                                                                                                                                       |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>St. Charles</b>              |                                                                                                                   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br><b>Troy</b>                                                                                                                                                                            |                               | c. CITY OR TOWN <b>St. Peters</b> <b>0920</b>                                                                                                               |                                                                                                                   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Lincoln Co. Mem. Hospital</b>                                                                                                                                     |                               | d. STREET ADDRESS (If outside, give location)<br><b>4 mi. so. on Olendorf Rd.</b>                                                                           |                                                                                                                   |
| Length of stay in lb <b>1 week</b>                                                                                                                                                                                                                  |                               | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                                                       |                                                                                                                   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Casimir</b> Middle <b>Sylvester</b> Last <b>Arnold</b>                                                                                                                                           |                               | 4. DATE OF DEATH<br>Month <b>Dec.</b> Day <b>4,</b> Year <b>1958</b>                                                                                        |                                                                                                                   |
| 5. SEX <b>male</b>                                                                                                                                                                                                                                  | 6. COLOR OR RACE <b>white</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Aug. 26, 1893</b>                                                                          |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>merchant</b>                                                                                                                                      |                               | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>groceries</b>                                                                                                       | 9. AGE (In years last birthday) <b>65</b><br>11. BIRTHPLACE (City and state or country)<br><b>St. Peters, Mo.</b> |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                          |                               | 13a. FATHER'S NAME<br><b>George Arnold</b>                                                                                                                  |                                                                                                                   |
| 13b. MOTHER'S MAIDEN NAME<br><b>Jennie Burra</b>                                                                                                                                                                                                    |                               | 14. NAME OF HUSBAND OR WIFE<br><b>Alice Arnold</b>                                                                                                          |                                                                                                                   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>                                                                                                                           |                               | 16. SOCIAL SECURITY NO.<br><b>496-14-3218</b>                                                                                                               |                                                                                                                   |
| 17. INFORMANT<br><b>Earl Arnold, RR 1, St. Peters, Mo.</b>                                                                                                                                                                                          |                               | Address                                                                                                                                                     |                                                                                                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b>                                                                                         |                               | INTERVAL BETWEEN ONSET AND DEATH                                                                                                                            |                                                                                                                   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <b>Arteriosclerosis</b>                                                                                                                    |                               |                                                                                                                                                             |                                                                                                                   |
| DUE TO (c) <b>Acute Cholecystitis</b>                                                                                                                                                                                                               |                               |                                                                                                                                                             |                                                                                                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>4201</b>                                                                                                    |                               | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                           |                                                                                                                   |
| 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<br>Hour <b>a.m.</b> Month, Day, Year <b>p.m.</b>                                                                                                                                                                                |                               |                                                                                                                                                             |                                                                                                                   |
| 20d. INJURY OCCURRED WHILE AT <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>Dec 1, 1958</b> to <b>Dec 4, 1958</b> and last saw her/him alive on <b>Dec 4, 1958</b><br>Death occurred at <b>7:00 pm</b> m on the date stated above; and to the best of my knowledge, from the causes stated. |                               |                                                                                                                                                             |                                                                                                                   |
| 22a. SIGNATURE<br><b>Harold A. Mangels DO</b>                                                                                                                                                                                                       |                               | 22b. ADDRESS<br><b>0 Fallon Mo</b>                                                                                                                          |                                                                                                                   |
| 22c. DATE SIGNED<br><b>Dec 6, 1958</b>                                                                                                                                                                                                              |                               |                                                                                                                                                             |                                                                                                                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Dec. 9, 1958</b>                                                                                                                                                                                    |                               | 23b. DATE                                                                                                                                                   |                                                                                                                   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Joseph Cemetery</b>                                                                                                                                                                                    |                               | 23d. LOCATION (City, town, or county) (State)<br><b>Cottleville, Mo.</b>                                                                                    |                                                                                                                   |
| 24. FUNERAL DIRECTOR<br><b>Geo. Stiefvater</b>                                                                                                                                                                                                      |                               | 25. DATE RECD. BY LOCAL REG.<br><b>12-8-58</b>                                                                                                              |                                                                                                                   |
| ADDRESS<br><b>St. Peters, Mo.</b>                                                                                                                                                                                                                   |                               | 26. REGISTRAR'S SIGNATURE<br><b>Charlotte Leek</b>                                                                                                          |                                                                                                                   |

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

# 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 Ed Keith

Licensed Embalmer No. 842  
P. O. Address Dallas, 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.