

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025683

X FILED VS JUL 29 1959 / 60

Registration District No. \_\_\_\_\_ Primary Registration District No. 559 Registrar's No. 110

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Jefferson</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rural Joachim</u> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION _____ Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY _____ c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>4215 Lafayette Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>WILLIAM E. ARNOLD</u>			<b>4. DATE OF DEATH</b> Month Day Year <u>July 18 1959</u>				
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>7-25-1893</u>	<b>9. AGE</b> (last birthday) <u>65</u>	<b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HR</b> Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Machine Operator-Park Dep't.-City of St. Louis</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Wayne Co., Mo.</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>U.S.A.</u>			
<b>13a. FATHER'S NAME</b> <u>George Arnold</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Henrietta McLaughlin</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>Late Bessie Arnold</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>489-09-9575</u>		<b>17. INFORMANT</b> Address <u>Thelma Dwyer 5660 Cabanne Ave.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TRAUMA Due to Auto Accident</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>                    </u>		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			<b>20a. ACCIDENT SUICIDE HOMICIDE</b> <u>Accident</u>				
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) <u>Two car accident.</u>			<b>PART III. If deceased was female was there a pregnancy in last 90 days.</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
<b>20c. TIME OF INJURY</b> Hour <u>5:30</u> Month, Day, Year <u>7/18/59</u>		<b>20d. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>					
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Highway</u>		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE <u>Joachim Twp. Jeff. Mo.</u>					
<b>21. I attended the deceased from</b> <u>August</u> to _____ and last saw him alive on _____ Death occurred at <u>5:30 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <u>James C. Schmitt M.D. Coroner</u>			<b>22b. ADDRESS</b> <u>Tuxedo, Mo</u>		<b>22c. DATE SIGNED</b> <u>7/20/59</u> (State)		
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Removal (Mtr)</u>		<b>23b. DATE</b> <u>July 22, 1959</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Carmel Cemetery</u>			
<b>23d. LOCATION</b> (City, town, or county) <u>Belleville, Ill.</u>		<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Kriegshauser 4228 S.Kingshighway</u>					
<b>25. DATE RECD. BY LOCAL REG.</b> <u>7-20-59</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>					

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUL 29 1959

JUL 28 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed William B. White

Licensed Embalmer No. 4291

P. O. Address 4228 de King

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.