URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS NOV 1 9 1959

59–041510

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 210200

ENDED

1. PLACE OF DEATH
a. COUNTY —
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis
Length of stay in 1b 2 YRS TMO
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Carrie Geitner Home 5000 So. Broadway
Inside Limits Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY —
c. CITY OR TOWN St Louis
Inside Limits Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) 4471 Olive St
Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First Laura Middle Lillian Last Arbaugh
Laura Lillian Arbaugh

4. DATE OF DEATH Month 11 Day 4 Year 1959

5. SEX F
6. COLOR OR RACE W
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH 7/16 '77
9. AGE (last birthday) 82
IF UNDER 1 YEAR Months 3 Days 18
IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher
10b. KIND OF BUSINESS OR INDUSTRY Public Schools
11. BIRTHPLACE (City and state or country) Columbus Ohio
12. CITIZEN OF WHAT COUNTRY U.S.A

13a. FATHER'S NAME Thomas Arbaugh
13b. MOTHER'S MAIDEN NAME Mary E Kimmel
14. NAME OF HUSBAND OR WIFE —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. ?
17. INFORMANT Mrs Louise Becker Address 5000 S. Broadway St. Louis

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH 2 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Generalized arteriosclerosis — 10 years
DUE TO (c) 420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Cerebral arteriosclerosis

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☑ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 1958, to 10/29/59 and last saw her/him alive on 10/29/59
Death occurred at 4:00 AM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) N. P. Krowlling MD
22b. ADDRESS 3720 Washington St Louis Mo
22c. DATE SIGNED 11/4/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation
23b. DATE 11-7-1959
23c. NAME OF CEMETERY OR CREMATORY Oak Grove Crematory
23d. LOCATION (City, town, or county) St Louis Co (State) Mo

24. FUNERAL DIRECTOR Mittelberg ADDRESS Webster Groves Mo
25. DATE RECD. BY LOCAL REG. NOV 6 1959
26. REGISTRAR'S SIGNATURE Carl Smith. M.D. MOB

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

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 m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____
Signature of Student Embalmer

Not Embalmed
Sam C Hattsberg

Licensed Embalmer No._____

P. O. Address_____

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