

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

8 1939

CORRECTED COPY
MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

REC'D JUN 8 1939

19852
 Do not use this space.

1. PLACE OF DEATH

(a) County Saint Louis Registration District No. 784
Carondelet

(b) Township Jefferson Barracks Primary Registration District No. 200
Unkn.

(c) City Jefferson Barracks (d) Street No. Veterans St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Lenzy WARREN

(a) Residence, No. 650 St. Anutt, Missouri.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city, or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs. Maude Warren

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 12, 1896

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	42	11	24	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer

9. Industry or business in which work was done, as saw mill, bank, etc. -

10. Date deceased last worked at this occupation (month and year) - 11. Total time (years) spent in this occupation -

12. BIRTHPLACE (CITY OR TOWN) Newburg, Missouri (STATE OR COUNTRY) 0

FATHER

13. NAME Grant Warren 0

14. BIRTHPLACE (CITY OR TOWN) - (STATE OR COUNTRY) Missouri 9

MOTHER

15. MAIDEN NAME (?) Insin

16. BIRTHPLACE (CITY OR TOWN) - (STATE OR COUNTRY) Not known

17. INFORMANT Clinical Clerk, VAF Jefferson Barracks, Missouri. (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE Annut, Mo. DATE May 10, 1939

19. FUNERAL DIRECTOR (NAME) Albert H Hoppe (ADDRESS) 4700 Washington

20. FILE MAY - 8 1939 G. R. Meyer, M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 6, 1939

22. I HEREBY CERTIFY, That I attended deceased from February 23, 1939 to May 6, 1939

I last saw him alive on May 6, 1939 Death is said to have occurred on the date stated above, at 7:28 P.M.

The principal cause of death and related causes of importance were as follows:

Myocarditis, chronic with marked cardiac hypertrophy following acute exacerbation (purulent) of chronic bronchitis. Date of onset Unkn.

Other contributory causes of importance: None 93C

Name of operation None Date of -
 What test confirmed diagnosis? Phy. clinical manif. and lab. Was there an autopsy? NO

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? - Date of injury -, 19-
 Where did injury occur? - (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury -
 Nature of injury -

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify C. W. Hughes
 (Signed) C. W. HUGHES, Chief Med. Officer, M. D.
VAF., Jefferson Barracks, Mo.

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.