

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **26872**
6768
Registrar's No.

Registration District No. **791** Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **BARNES HOSPITAL**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days) **11**

3. (a) PRINT FULL NAME **VERSIE BELL WARFORD**
3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Ernest Warford** 6. (c) Age of husband or wife if alive **43** years
7. Birth date of deceased **Dec 5th 1906**
(Month) (Day) (Year)

8. AGE: Years **33** Months **8** Days **3** If less than one day hr. min.

9. Birthplace **Ky.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business
MOTHER FATHER
12. Name **Jerry Simmons**
13. Birthplace **Ky.**
(City, town, or county) (State or foreign country)
14. Maiden name **Nora Charlton**
15. Birthplace **Ky.**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Ernest Warford**
(b) Address **921 a North 18th St**

17. (a) **Burial** (b) Date thereof **8/10/40**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Providence Ky.**

18. (a) Signature of funeral director **Stroot - Carroll**
(b) Address **4600 Natural Bridge Ave**

19. (a) **AUG 8 1940** (b) **J. J. Bredeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
0
(a) State **Missouri** (b) County _____
(c) City or town **St. Louis North 18th St 21**
(If outside city or town limits, write "RURAL")
(d) Street No. **921 a No. 18th St.**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Aug.** day **8**
year **1940** hour **11** minute **00** A.M.
21. I hereby certify that I attended the deceased from **Aug. 6**, 19**40**, to **August 8**, 19**40**;
that I last saw him alive on **August 8**, 19**40**;
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of breast with cerebral metastasis** Duration **1 1/2 yrs**
Due to _____
Due to **50**
Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy **Metastasis to liver, lung & brain**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **N. P. Bierman, M.D.** (M. D. or other)
Address **BARNES HOSPITAL** Date signed _____

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.

Aug 29 1969

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..... *Frank H. Strong*

Licensed Embalmer No. 2265

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.