

FILED DEC 12 1945
Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
5512 Delmar Boulevard
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **5512 Delmar Boulevard**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Alice M. Warner**

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 **Widowed**

6. (b) Name of husband or wife **George F. Warner** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Dec 14, 1859**
(Month) (Day) (Year)

8. AGE: Years **85** Months **11** Days **18** If less than one day
hr. _____ min. _____

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

10. Usual occupation **At Home**

11. Industry or business _____

12. Name **Elijah Grosslander**

13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

14. Maiden name **Margaret Strickler**

15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Miss. Ruby Warner**

(b) Address **5512 Delmar Boulevard**

17. (a) **Burial** (b) Date thereof **13/2/45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Bowen, Illinois**

18. (a) Signature of funeral director **Shepard Funeral Home**

(b) Address **1167 Hamilton Avenue**

19. (a) **DEC 2 1945** (b) **J. F. Bredich**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **30**, 1945
year **10** hour **03** minute **P** M.

21. I hereby certify that I attended the deceased from **September, 1935** to **Nov. 30, 1945**
that I last saw him alive on **Oct 1, 1945**
and that death occurred on the date and hour stated above.

Immediate cause of death **Acute coronary occlusion**
Due to **Chronic coronary sclerosis 2 yrs**

Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: **940**
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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?

(Specify type of place)
While at work? _____ (e) Means of injury _____
23. Signature **William B. Day** (M. D. or other) _____
Address **3720 Washington** Date signed **12-1-45**

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

MOTHER FATHER

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

John Agnoski

Licensed Embalmer No. *3398*

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, fact should be so stated above.