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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED JUN 20 1946

1003

5008

Registration District No. 318

Primary Registration District No. ....

Registrar's No. ....

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:  
St Anthony  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days  
(Specify whether Life)

In this community Life  
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 0000

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 5243 Chippewa Street  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Dr Fred Gail Warner

3. (b) If veteran, name war. ....

3. (c) Social Security No. ....

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Cora K Warner

6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased March 4 1946  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

70 3 0 hr. min.

9. Birthplace Buffalo New York  
(City, town, or county) (State or foreign country)

10. Usual occupation Physician

11. Industry or business

12. Name Charles M Warner

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

14. Maiden name Unknown

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

16. (a) Informant Edwin M Warner

(b) Address 5243 Chippewa, St. Louis, Missouri

17. (a) Burial (b) Date thereof June 6, 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation Support Burial

18. (a) Signature of funeral director 6464 Chippewa, St. Louis, Missouri

(b) Address J. F. Bredeck

19. (a) JUN 4 1946 (b) J. F. Bredeck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 4  
year 1946 hour 7 minute 00 A.M.

21. I hereby certify that I attended the deceased from March 14, 1944 to June 4, 1946  
that I last saw him alive on June 3, 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death: Atherosclerosis of heart disease 4 yrs, myocardial infarction 3 wks, congestive heart failure 3 wks

Duration 4 yrs, 3 wks, 3 wks

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations None

Of autopsy None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no

(b) Date of occurrence None

(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 0

3. Signature R. V. Purcell (M. D. Missouri)  
Address 3720 Washington Date signed 6-4-46

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

MOTHER FATHER

PHYSICIAN  
Underline the cause to which death should be charged statistically.

Dr Powell  
3720 Washington  
Dr Robert G Warner

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 *Harry J Schencker*  
Licensed Embalmer No. *2679*  
P. O. Address *7814 S. Broadway.*

**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.**