

3. No. 2  
-12-45  
5-17-39  
P I X47070

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 42087  
Registrar's No. 3657

FILED JAN 31 1947  
Registration District No. 3

Primary Registration District No. 6076

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

1. PLACE OF DEATH:

(a) County ST LOUIS

(b) City or town BALLWIN, MO.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
PINE CREST NUR HOME  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 mo. 5  
(Specify whether years, months or days)

In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME George M. Warren

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 WIDOWER

6. (b) Name of husband or wife LILLIE WARREN

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

7. Birth date of deceased JAN 25 1872  
(Month) (Day) (Year)

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

<u>74</u>	<u>11</u>	<u>6</u>	hr. _____ min. _____
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9. Birthplace: \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation RETIRED

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name GEORGE WARREN

13. Birthplace UNKNOWN  
(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 MR GEORGE WARREN JR

(b) Address CENTERVILLE, MO.

17. (a) BURIAL (b) Date thereof 1-3-1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation LESTERVILLE MO.

18. (a) Signature of funeral director ROWLAND SERVICE

(b) Address 4355 WASHINGTON AV.

19. (a) 1-6-47 (b) Ruth G Allen M.D.  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State ILLINOIS (b) County \_\_\_\_\_

(c) City or town COLLINSVILLE  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 31  
year 1946 hour 9 minute 45 P. M.

21. I hereby certify that I attended the deceased from November 24  
1946, to December 31, 1946  
that I last saw him alive on Dec 30, 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death central embolus  
chronic myocarditis

Due to generalized arteriosclerosis

Due to 93d

Other conditions (Include pregnancy within 3 months of death)

Major findings:  
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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature A. T. Mordkin M.D. (M. D. or other) M.D.

Address 2502 Potomac Date signed 1-3-47

JAN 9 1947

**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 Ketter* .....

Licensed Embalmer No. *3880* .....

P. O. Address *St. Louis Mo* .....

**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.**