

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 5 1947
318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

11665
State File No. _____
Registrar's No. 2936

Registration District No. _____ Primary Registration District No. _____

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:
4239 West Aldine
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 40 Yrs.
(Specify whether
In this community 40 Yrs.
" years, months or days)

3. (a) PRINT FULL NAME John Warren
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Jennie Warren 6. (c) Age of husband or wife if alive 60 years
7. Birth date of deceased Unavailable 1885
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
About 62 - - hr. min.

9. Birthplace Unavailable Tennessee
(City, town, or county) (State or foreign country)

10. Usual occupation Houseman

11. Industry or business _____

MOTHER FATHER
12. Name Charles Warren
13. Birthplace Unavailable Tennessee
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unavailable Tennessee
(City, town, or county) (State or foreign country)

16. (a) Informant Jennie Warren
(b) Address 4230 W. Aldine

17. (a) Burial (b) Date thereof 3-21-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peters Cemetery

18. (a) Signature of funeral director Charles J. Gates

(b) Address 4107 Finney Ave.

19. (a) MAR 19 1947 (b) J. F. Bredbeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County adao
(c) City or town St. Louis 11/7
(If outside city or town limits, write "RURAL") 9
(d) Street No. 4230 W. Aldine
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 15th
year 1947 hour 8:30 minute P.M. M.

21. I hereby certify that I attended the deceased from 3/10/47
1947, to 3/15 1947
that I last saw h. alive on 3/15 1947
and that death occurred on the date and hour stated above.

Immediate cause of death
Acute Myocarditis
from 3 days

Due to _____
Due to _____

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

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
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)
(b) Means of injury _____
Signature Charles J. Gates (M.D. or dentist)
Address 3146a Laclede Date signed 3/19/47

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

STATEMENT BY LICENSED EMBALMER

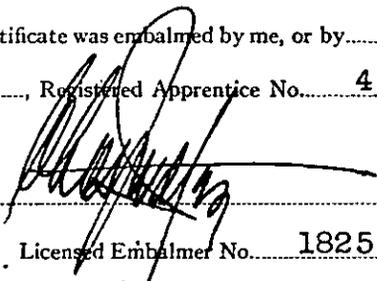
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

John K. Cunningham

Registered Apprentice No. **452**

working under my personal supervision.

Signed.....


Licensed Embalmer No. **1825**

P. O. Address..... **4107 Finney Ave.**

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.