. No. 2
I—5-43
5-17-39
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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. 29634

Registration District No. FILED SEP 2 1948 Primary Registration District No. 1003 Registrar's No. 7901

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

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or ~~institution~~: St. Louis Childrens Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or ~~institution~~ 13 hr. 5 min. (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County St. Clair 999

(c) City or town East St. Louis 11
(If outside city or town limits, write "RURAL")

(d) Street No. 1713 State St. 0
(If rural, give location)

N.R.

(e) Citizen of foreign country? (Yes or No) 21

If yes, name country

3. (a) PRINT FULL NAME Charles Bruce Warner

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife

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

7. Birth date of deceased August (Month) 15 (Day) 1947 (Year)

8. AGE: Years	Months	Days	If less than one day
0	0	4	13 hr. 30 min.

9. Birthplace East St. Louis (City, town, or county) Illinois (State or foreign country)

10. Usual occupation Infant

11. Industry or business

FATHER
12. Name Charles Henry Warner
13. Birthplace Carlyle (City, town, or county) Illinois (State or foreign country)

MOTHER
14. Maiden name Dorothy Gamlin
15. Birthplace East St. Louis (City, town, or county) Illinois (State or foreign country)

16. (a) Informant Chas. M. Burke
(b) Address East St. Louis, Ill

17. (a) removal (Burial, cremation, or removal) (b) Date thereof Aug. 20, 1947 (Month) (Day) (Year)
(c) Place: burial or cremation East St. Louis, Ill

18. (a) Signature of funeral director Chas. M. Burke
(b) Address East St. Louis, Ill

19. (a) AUG 20 1947 (Date received local registrar) (b) J. F. Bradeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 19
year 1947 hour 1 minute 30 P.M.

21. I hereby certify that I attended the deceased from 8-19-47 (12:25 A.M.), 1947, to 8-19 (1:30 P.M.), 1947; that I last saw him alive on 8-19, 1947; and that death occurred on the date and hour stated above.

Immediate cause of death diarrhea of newborn c̄ acidosis & sepsis.
Not Premature

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

119a

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 0

23. Signature R. J. Blattner (M. D. or other)

Address JW Dr. Kingston Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 Chas M. Burke

Licensed Embalmer No. 2421

P. O. Address E. St. Louis Ill

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.