

STANDARD CERTIFICATE OF DEATH

40307
State File No. 10523
Registrar's No.

FILED NOV 28 1947 318
Registration District No.

Primary Registration District No. 1003

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

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. Louis Children's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 3 mo 1 day
(Specify whether)

In this community: _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

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

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

(d) Street No.: 514a Collinsville
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country: _____

3. (a) PRINT FULL NAME: Sharon Elizabeth Warren

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

3. (c) Social Security No.: _____

4. Sex: female

5. Color or race: white

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

6. (b) Name of husband or wife: _____

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

7. Birth date of deceased: 8-19-47
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: 11 day: 13
year: 47 hour: 4 minute: 50 P.M.

21. I hereby certify that I attended the deceased from 8-12-47 to 11-13-47
that I last saw her alive on 11-13-47
and that death occurred on the date and hour stated above.

Duration: _____

Immediate cause of death: Cancer lymphoma of neck, causing suffocation

8. AGE:

Years	Months	Days	If less than one day
<u>3</u>	<u>3</u>	<u>32</u>	hr. _____ min. _____

Due to: _____

Due to: 15/6

Other conditions: _____
(include pregnancy within 3 months of death)

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

PHYSICIAN

Major findings: _____

Of operations: _____

Of autopsy: _____

Underline the cause of which death should be charged statistically.

10. Usual occupation: _____

11. Industry or business: _____

12. Name: Dale Warren

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

14. Maiden name: Helen Gilbert

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

16. (a) Informant: Dale Warren

(b) Address: 514a Coll Ave

17. (a) _____ (b) Date thereof: 11-13-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: St. Louis Ill

18. (a) Signature of funeral director: Robert J. ...

(b) Address: East St. Louis Ill

19. (a) 11/15/47 (b) J. F. ...
(Date received local registrar) (Registrar's signature)

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: Gilbert B. ... (M. D. or other) MD
Address: 505 St. Kings Highway Date signed: 11-13-47

88501

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 me

..... Registered Apprentice No.
working under my personal supervision.

Signed Frank Prokoff

Licensed Embalmer No. 4356

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.