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

#75250

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED DEC 8 1948

Registration District No. 318

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 38748

Registrar's No. 10428

1. PLACE OF DEATH:

(a) County St.Louis,Missouri.

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

(c) Name of hospital or institution: St.Louis City Hospital - Max C.Starkloff (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 0 2 days (Specify whether years, months or days)

In this community newborn

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 96

(c) City or town St.Louis 5 (If outside city or town limits, write "RURAL")

(d) Street No. 2031 Alameda,Maplewood,Mo. 3 (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Infant ~~BABY BOY~~ WARDEN

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

3. (c) Social Security No.

4. Sex male 0

5. Color or race white

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

6. (b) Name of husband or wife

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

7. Birth date of deceased October 19th,1948 (Month) (Day) (Year)

8. AGE: Years | Months | Days 2 | If less than one day hr. min.

9. Birthplace St.Louis City Hospital - 0 (City, town, or county) (State or foreign country)

10. Usual occupation nil

11. Industry or business

MOTHER FATHER

12. Name Walter Warden 1

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

14. Maiden name Jackson Missouri 0

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

16. (a) Informant St.Louis City Hospital

(b) Address 1515 Lafayette

17. (a) Anatomical Board (Burial, cremation, or removal) (b) Date thereof NOV 30 1948 (Month) (Day) (Year)

(c) Place: burial or cremation Anatomical Board

18. (a) Signature of funeral director Rowland Mortuary Service

(b) Address 4106 Manchester Ave.

19. (a) NOV 30 1948 (Date received local registrar) (b) J.B Lafaster (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 21st year 1948 hour 6 minute 45 P M.

21. I hereby certify that I attended the deceased from Oct. 19th 1948, 19..., to Oct. 21st, 19 48 that I last saw him alive on Oct. 21st, 19 48 and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity

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.

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 E.L Washington (M. D. or other)

Address 1515 Lafayette Date signed 10/22/48

(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.....

Licensed Embalmer No.....

P. O. Address.....

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.