

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED FEB 2 1949

State File No. 3369
320

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|--|---------------------------|--|-----------------------------------|---|----------------------------------|
| BIRTH NO. | | REG. DIST. NO. 318 | PRIMARY REG. DIST. NO. 1003 | Registrar's No. | |
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) St. Louis | | c. CITY (If outside corporate limits, write RURAL and give township) St. Louis | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION enroute to City Hospital | | d. STREET ADDRESS (If rural, give location) 821 Chestnut Ave. | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) Roy bren b. (Middle) c. (Last) Warren | | 4. DATE OF DEATH (Month) (Day) (Year) 1 16 1949 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED: NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married | 8. DATE OF BIRTH July 11, 1896 | 9. AGE (In years, last birthday) Months Days Hours Min. 52 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY Machinist | | 11. BIRTHPLACE (State or foreign country) Center City, Illinois | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | 13a. FATHER'S NAME James D. Warren | | | |
| 13b. MOTHER'S MAIDEN NAME Elizabeth Sanders | | 14. NAME OF HUSBAND OR WIFE None | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes World War No 1 | | 16. SOCIAL SECURITY 498-05-4513 | | 17. INFORMANT'S SIGNATURE OR NAME Edna Schneider 323 Eldredge Rock Hill | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hemorrhagic Pancreatitis DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 178 587 | | | INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 7:40 A.M., from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE Patrick E. Taylor Carover | | 22b. ADDRESS 1300 Clark | | 22c. DATE SIGNED 1-18-49 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 24b. DATE 1-19-49 | | 24c. NAME OF CEMETERY OR CREMATORY Lebanon Cemetery | |
| 24d. LOCATION (City, town, or county) (State) Lebanon, Illinois | | 25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe Inc 4700 Washington | | | |
| DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE JAN 18 1949 J. B. Foster | | 25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe Inc 4700 Washington | | | |

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

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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Robert M Murray

Licensed Embalmer No. 3749

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.