

FILED JUL 30 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 25382  
6436

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 OR TOWN St. Louis		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN St. Louis		d. STREET ADDRESS (If rural, give location) 4965a St. Louis Ave.			
d. FULL NAME OF HOSPITAL OR INSTITUTION 4965a St. Louis Ave.									
3. NAME OF DECEASED (Type or Print) Leo A. Warneke			a. (First)			b. (Middle) /			
			c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) 7/24/49			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 6/23/1893		9. AGE (in years last birthday) 56	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) St. Louis, Mo.			12. CITIZEN OF WHAT COUNTRY? _____		
13a. FATHER'S NAME Michael Warneke			13b. MOTHER'S MAIDEN NAME Frances Schultz			14. NAME OF HUSBAND OR WIFE Stella M. Warneke			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. 490-01-5959		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Stellam. Warneke, 4965a St. Louis				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Carcinoma of Stomach</i>						INTERVAL BETWEEN ONSET AND DEATH 1 yr	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing 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) _____		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? <i>Hip</i> <i>151X</i>	
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 _____ m., from the causes and on the date stated above.									
23a. SIGNATURE <i>J. K. Mistachkin MD</i>					23b. ADDRESS <i>4887 Washington</i>			23c. DATE SIGNED <i>7/25/49</i>	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 7/27/49		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) St. Louis, Mo.			
DATE REC'D BY LOCAL REG. JUL 25 1949		REGISTRAR'S SIGNATURE <i>J. B. Laster</i>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Sullivan Funeral Dir. 2849 Euclid				

WRITE PLAINLY—USING 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.....

working under my personal supervision.

Student Embalmer No.....

Signed

*Gustav W. Dulude*

Signed.....  
Student Embalmer

Licensed Embalmer No. *4329*

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.