

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32305**
8275

FILED OCT 7 1949

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) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION St. Louis Sisters of Poor 3400 S. Grand Blvd.		d. STREET ADDRESS (If rural, give location) 3400 S. Grand Blvd.	
3. NAME OF DECEASED (Type or Print) Albert Warner		4. DATE OF DEATH (Month) (Day) (Year) September 26, 1949	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH Mar. 10, 1877
9. AGE (In years last birthday) 72		10. MONTHS 6	11. DAYS 16
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) Buma, Switzerland
12. CITIZENSHIP OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Jacob Warner	
13b. MOTHER'S MAIDEN NAME Katherine Ruge		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Sister Irene		ADDRESS 3400 S. Grand Blvd.	
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 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Generalized Arteriosclerosis DUE TO (c) 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	
19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20. DATE OF OPERATION	
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) St. Louis, 3, Mo. 97		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? Asst	
22. I hereby certify that I attended the deceased from July 1947 , to Sept. 26, 1949 , that I last saw the deceased alive on Sept 21, 1949 , and that death occurred at 4:30 A m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) R. A. Meyers M.D.		23b. ADDRESS 539 N. Grand	
23c. DATE SIGNED 9/26/49		23d. DATE	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 9/27/49	
24c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis MO.	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE SEP 26 1949 J. B. Lasater		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John H. Gebken Sons Und. Co. 2630 Gravois Ave.	

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

Robert T. Gebken

Signed _____
Student Embalmer

Licensed Embalmer No. 4144

P. O. Address 3400 S. Grand Blvd.

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.