

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10725**
Registrar's No. **2815**

FILED APR 12 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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. LENGTH OF STAY (in this place) 2 yrs.	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2249	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1946 Cherokee St.		d. STREET ADDRESS (If rural, give location) 1946 Cherokee St.	

3. NAME OF DECEASED (Type or Print) a. (First) Mary	b. (Middle) L.	c. (Last) Warren	4. DATE OF DEATH (Month) (Day) (Year) March 25, 1952
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Feb. 20, 1879	9. AGE (In years last birthday) 73	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 MIN. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Esser, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Frank
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Earnest Warren	ADDRESS 1946 Cherokee St.
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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		INTERVAL BETWEEN ONSET AND DEATH ?
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocardial Disease		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? H222

22. I hereby certify that I attended the deceased from **2-13, 1952**, to **2-25, 1952**, that I last saw the deceased alive on **2-22, 1952**, and that death occurred at **9:15a m.**, from the causes and on the date stated above.

23a. SIGNATURE O. Jones	(Degree or title) M.D.	23b. ADDRESS 3616 S. Bolwy St. S. Louis	23c. DATE SIGNED 3-25-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 3-25-52	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Dexter, Mo.
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE MAR 25 1952 J. Earl Smith, M.D., Reg.	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	ADDRESS 4700 Washington Blvd.
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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~~ Me

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed W. W. Wilkinson

Licensed Embalmer No. 3575

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.