

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35404

State File No. \_\_\_\_\_

No. 300  
10-48

FILED NOV 10 1955

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>541</u>		Registrar's No. <u>2450</u>	
1. PLACE OF DEATH a. COUNTY <u>Saint Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institutional: evidence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Clayton</u>		c. LENGTH OF STAY (in this place) <u>D.O.A.</u>		c. CITY OR TOWN <u>Kinloch</u> <u>409</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis County Hosp.</u>				e. STREET ADDRESS (If rural, give location) <u>712 King Street</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Ertha</u>			b. (Middle) <u>Lee</u>		c. (Last) <u>Warren</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 23 1955</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>March 11, 1928</u>		9. AGE (In years last birthday) <u>27</u>	IF UNDER 1 YEAR Months	IF UNDER 14 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Medicine</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Kinloch, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Horace Warren</u>			13b. MOTHER'S MAIDEN NAME <u>Ethel Brooks</u>		14. NAME OF HUSBAND/OR WIFE <u>N/A</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>UNK</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Rosie Lee Dowdy Kinloch, Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Death was attributed to multiple</u>  ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>gunshot wounds (homicidal) with</u> DUE TO (c) <u>fatal brain damage.</u>  II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>						INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION  <u>E981X</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Homicide</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>home</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Kinloch St. Louis Mo.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>Oct. 23, 1955 2:30 a.m.</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Gunshot wounds inflicted by Mack McCloud</u>			
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 (Degree or title) <u>Arnold J. Willman, Crown</u>				23b. ADDRESS <u>Clayton, Mo.</u>		23c. DATE SIGNED <u>10-27-55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Oct. 28, 55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Washington Park</u>		24d. LOCATION (City, town, or county) (State) <u>Berkley Mo.</u>		
DATE REC'D BY LOCAL REG. <u>10-24-55</u>		REGISTRAR'S SIGNATURE <u>Herbert R. Dombrowski</u>		FUNERAL DIRECTOR'S SIGNATURE <u>BOYD BROS FUNERAL HOME</u>		ADDRESS <u>4381x, Kinloch</u>	

S.C. (Licensed Embalmer's Statement on Reverse Side)

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..

Student.....  
Signature of Student Embalmer

Signed *Donald C. Heyman*

Licensed Embalmer No. *4442*

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.