No. 300
10.48

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

FILED JAN 26 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3085

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 354

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ST. LOUIS
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1009 N. 20th ST.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: MISSOURI
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ST. LOUIS
d. STREET ADDRESS (If rural, give location): 21 1009 N. 20th ST. 2219

3. NAME OF DECEASED (Type or Print)
a. (First): ALEXANDER
b. (Middle):
c. (Last): WARFIELD

4. DATE OF DEATH (Month) 1 (Day) 6 (Year) '56

5. SEX: MALE

6. COLOR OR RACE: NEGRO

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED

8. DATE OF BIRTH: 1899

9. AGE (In years last birthday): 56
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

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): KENTUCKY

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: UNKNOWN

13b. MOTHER'S MAIDEN NAME: ELIZABETH WHITLOCK

14. NAME OF HUSBAND OR WIFE: ROSIE WARFIELD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: UNKNOWN

17. INFORMANT'S SIGNATURE OR NAME: Rosie Warfield
ADDRESS: 1009 N. 20th St.

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Failure (Heart)

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.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION: 434.1

20. AUTOPSY? YES ☑ NO ☐

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 ☐ NOT WHILE AT WORK ☐

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* 1245 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Patrick F. Taylor Coroner

23b. ADDRESS: 1300 Clark

23c. DATE SIGNED: 1.11.56

24a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL

24b. DATE: 1/14/56

24c. NAME OF CEMETERY OR CREMATORY: Oakdale Cemetery

24d. LOCATION (City, town, or county) (State): St. Louis County, Mo.

DATE REC'D BY LOCAL REG.: JAN 11 1956

REGISTRAR'S SIGNATURE: J. Carl Smith M.D.

25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Luke Jones 1343 N. Garrison

(Licensed Embalmer's Statement on Reverse Side)

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 Arthur L. Hellard

Signed.....
Student Embalmer

Licensed Embalmer No. 4221

P. O. Address 4107 Fenner

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.