

FILED DEC 20 1957

STANDARD CERTIFICATE OF DEATH

46895

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2969

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

| | | | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|--------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY St. Louis | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Normandy | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN Robertson 4000 | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Normandy Osteopathic | | | Length of stay in lb 3 hrs. | | | d. STREET ADDRESS (If outside, give location) Rt. 2 Box 187 | | |
| 3. NAME OF DECEASED (Type or print) First Nalma Middle Louise Last Warren | | | | 4. DATE OF DEATH Month Nov. Day 25 Year 1957 | | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 6/15/10 | | 9. AGE (In years last birthday) 47 | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HRS. Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during months working life, even if retired) House work | | 10b. KIND OF BUSINESS OR INDUSTRY Home Maker | | 11. BIRTHPLACE (City and state or country) Boss Missouri | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME Manuel Brooks | | | | 14. MOTHER'S MAIDEN NAME Nora Martin | | | | |
| 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 495-22-2032 | | 17. INFORMANT Scott Warren | | Address Rt. 2 Robertson Mo. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 Hrs. | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | DUE TO (b) Hypertension | | 331X | | | | |
| | | DUE TO (c) Atherosclerosis | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2 | |
| 20a. ACCIDENT <input type="checkbox"/> | SUICIDE <input type="checkbox"/> | HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ | | | | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION Salem | | STATE Missouri | | |
| 21. I attended the deceased from June 17, 1957 to Nov. 25, 1957 and last saw her <u>him</u> alive on Nov. 25, 1957 . Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE R. H. Kohler, D.D. (Degree or title) | | | | 22b. ADDRESS 3448 Brown Rd. St. Louis 21, Mo | | 22c. DATE SIGNED 11-25-57 | | |
| 23a. BURIAL, CREMATION, REPOULCHRE (Specify) Burial | | 23b. DATE 11/27/57 | 23c. NAME OF CEMETERY OR CREMATORY Boss Cemetery | | 23d. LOCATION (City, town, or county) (State) Salem Missouri | | | |
| 24. FUNERAL DIRECTOR Collier Mortuary St. Ann Mo. | | | ADDRESS | | 25. DATE RECD. BY LOCAL REG. 11-26-57 | 26. REGISTRAR'S SIGNATURE Herbert R. Donike MD | | |

DEC 29 1931

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..... *Sheldon Collier*

Licensed Embalmer No. 33

P. O. Address St. Ann

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.