

FILED FEB 6 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

3761

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1114**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>En Route to City Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>1470 5108 Eichelberger Ave</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>RALPH</b> b. (Middle) <b>THOMAS</b> c. (Last) <b>WARNACK</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>1-27-1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Divorced</b>	8. DATE OF BIRTH <b>12-5-1902</b>
9. AGE (In years last birthday) <b>55</b>		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Business Administrator U.S. Government</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>Thomas S. Warnack</b>	
13b. MOTHER'S MAIDEN NAME <b>Helene Munslinger</b>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Mathilda Munslinger</b>	
17. INFORMANT'S SIGNATURE OR NAME <b>Mathilda Munslinger</b>		ADDRESS <b>5108 Eichelberger Ave</b>	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION <b>CARDIAC DECOMPENSATION</b>  <b>ARTERIOSCLEROTIC HT. DIS</b>  <b>420.0</b>	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		INTERVAL BETWEEN ONSET AND DEATH <b>4 mos</b>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <b>4 mos.</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 checked="" type="checkbox"/>			
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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>12/27, 1957</b> , to <b>1/27, 1958</b> , that I last saw the deceased alive on <b>1/28, 1958</b> , and that death occurred at <b>8:15 P. m.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>[Signature]</b>		23b. ADDRESS <b>634 N. Grand</b>	23c. DATE SIGNED <b>1/30/58</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>1-30-1958</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Sunset Burial Park</b>	24d. LOCATION (City, town, or county) (State) <b>10160 Gravois Road Mo</b>
DATE REC'D BY LOCAL REG. <b>JAN 30 '58</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith, M.D.</b>	
25. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b>		ADDRESS <b>6409 Gravois Ave</b>	

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

Dr. Agness 634 N. Grand  
OL 2-3868

9 to 12

**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..... *Wm M. Sizemore* .....  
Licensed Embalmer No. 434  
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.