Health, & Welfare Public Service

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70286-58

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-034986
STATE FILE NUMBER

FILED OCT 6 1958 Registration District No. 317 Primary Registration District No. 544 Registrar's No. 2477

1. PLACE OF DEATH
a. COUNTY: St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Kirkwood — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St. Joseph — Length of stay in 1b: 5 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: St. Louis
c. CITY OR TOWN: Valley Park 4761 — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 409 Benton — Reside on Farm: Yes [X] No [ ]

3. NAME OF DECEASED (Type or print): First: MARGARET Middle: GLENDA Last: Warner

4. DATE OF DEATH Month Day Year: 9/24/58

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED [ ] **NEVER MARRIED** [X] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: 9/19/58

9. AGE (In years last birthday): IF UNDER 1 YEAR: Months: Days: 5 — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: ------

11. BIRTHPLACE (City and state or country): Kirkwood, Mo.

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: Richard Warner

13b. MOTHER'S MAIDEN NAME: Annie Thompson

14. NAME OF HUSBAND OR WIFE: --------

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.: none

17. INFORMANT Address: Richard Warner, 409 Benton, Valley Park, Mo.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Left lower lobe Aspiration Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Hyaline membrane disease — 20 hrs
DUE TO (c): 763.5
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Premature infant

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT [ ] **SUICIDE** [ ] **HOMICIDE** [ ]

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. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

All diseases in Part I must be causally related.

21. I attended the deceased from 9/19, to 9/24 and last saw her/him alive on 9/24
Death occurred at 9/24/58-3:45 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): M Edwards M.D.

22b. ADDRESS: Kirkwood 22, Mo

22c. DATE SIGNED: 9/24/58

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 9/26/58

23c. NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery.

23d. LOCATION (City, town, or county) (State): Kirkwood, Mo.

24. FUNERAL DIRECTOR ADDRESS: Schrader Funeral Home, Ballwin, Mo.

25. DATE RECD. BY LOCAL REG.: 9-26-58

26. REGISTRAR'S SIGNATURE: Herbert R. Donke M.D.

(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.

Student .....
Signature of Student Embalmer

Signed Richard M. Bapp

Licensed Embalmer No. 4584

P. O. Address Baldwin, M

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.