

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-042904
STATE FILE NUMBER

FILED NOV 17 1958 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2824

300
1-57

1. PLACE OF DEATH a. COUNTY ST LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY ST LOUIS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN BALLWIN		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN 40660 ST. L. COUNTY
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION PINECREST N.H. #1		Length of stay in lb 16 MONS	d. STREET ADDRESS (If outside, give location) 2819 LYNDBURST
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH ARTHUR WARNER			4. DATE OF DEATH Month Day Year 11-3-58		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-31-1888	9. AGE (In years less birthday) 73	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED-MECHANIC		10b. KIND OF BUSINESS OR INDUSTRY FRISCO R.R.	11. BIRTHPLACE (City and state or country) LOUISVILLE MISS. 1	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME ELIZAH WARNER		13b. MOTHER'S MAIDEN NAME ELIZA RICHARDSON		14. NAME OF HUSBAND OR WIFE IDA L. WARNER (DECEASED)	
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. 490-05-4353	17. INFORMANT Address 2819 LYNDBURST ST LOUIS MO WAGGAGE Joseph, WARNER		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Insufficiency			INTERVAL BETWEEN ONSET AND DEATH 1 day
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Mitral Valve Insufficiency			
DUE TO (c) Rheumatic Fever			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 410X			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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 Month, Day, Year a.m. p.m.			

20d. INJURY OCCURRED WHILE AT <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 COUNTY STATE
21. I attended the deceased from May 2nd, 58 to Oct 30, 58 and last saw her/him alive on Oct. 30, 1958 Death occurred at 2:05 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) Ralph W. Kaffey, R.P.	22b. ADDRESS Box 122, Mendocino, Ca.	22c. DATE SIGNED 11-3-58

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 11-5-58	23c. NAME OF CEMETERY OR CREMATORY MOUNT LEBANON	23d. LOCATION (City, town, or county) ST. ANN	(State) MO
24. FUNERAL DIRECTOR Paul Williams 9209 Jackson	ADDRESS	25. DATE RECD. BY LOCAL REG. 11/4/58	26. REGISTRAR'S SIGNATURE Herbert R. Douke M.D.	

(Licensed Embalmer's Statement of Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms written be inserted. All diseases in Part I must be causally related.

D.M.

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 *Carl H. Hillman*

Licensed Embalmer No. *3501*
P. O. Address *Garland, W. Va.*

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.