

FILED JUL 13 1959

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH59-023509  
State File No. ....BIRTH NO. \_\_\_\_\_ REG. DIST. NO. \_\_\_\_\_ PRIMARY REG. DIST. NO. \_\_\_\_\_ Registrar's No. **2 6116**

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Missouri</b><br>b. COUNTY |   |
| b. CITY (If outside corporate limits, write RURAL and give township)<br><b>St. Louis</b> |  | c. CITY OR TOWN<br><b>St. Louis</b>   | d. Is Residence within limits of a city or incorporated town?<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. LENGTH OF STAY (In this place)  |  | e. STREET ADDRESS (If rural, give location)<br><b>1244 Goodfellow</b>   |   |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Homer G. Phillips Hosp</b>                 |  |   |   |

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 3. NAME OF DECEASED<br>(Type or Print)<br><b>Robert Warren</b>  |                                  | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>6. 25. 59</b>                            |  |
| a. (First)  | b. (Middle)                      | c. (Last)  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>Negro</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>             | 8. DATE OF BIRTH<br><b>Jan 23-18.88</b>                                  |
| 9. AGE (In years last birthday)<br><b>71</b>  |                                  | IF UNDER 1 YEAR: MONTHS _____ DAYS _____<br>IF UNDER 18 HRS.: HOURS _____ MIN. _____ |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Lab. or</b> |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>                                     | 11. BIRTHPLACE (City and State or Foreign Country)<br><b>Mississippi</b> |
|   |                                  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                            |

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 13a. FATHER'S NAME<br><b>Unk</b>  |  | 13b. MOTHER'S MAIDEN NAME<br><b>Unk</b> |  | 14. NAME OF HUSBAND OR WIFE<br><b>Arlna Warren</b>                               |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b> |  | 16. SOCIAL SECURITY NO.<br><b>No</b>    |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br><b>Arlna Warren 1244 Goodfellow</b> |  |

|  |  |   |  |                                  |  |
|--|--|---|--|----------------------------------|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)  |  | MEDICAL CERTIFICATION   |  | INTERVAL BETWEEN ONSET AND DEATH |  |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Occlusion</b>   |  | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <b>Coronary Sclerosis</b> |  |                                  |  |
| *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. |  | DUE TO (c)  |  | <b>420.1</b>                     |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>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? <input checked="" type="checkbox"/> YES <input type="checkbox"/> 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) (Min.) |  | 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 \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at **11:55 P.M.**, from the causes and on the date stated above.

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 23a. SIGNATURE<br><b>Patrick Taylor Carraway</b>            |  | (Degree or title) <b>3</b>                       |  | 23b. ADDRESS<br><b>1300 Clark</b>                            |  | 23c. DATE SIGNED<br><b>6-29-59</b>  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b> |  | 24b. DATE<br><b>6-29-59</b>                      |  | 24c. NAME OF CEMETERY OR CREMATORY<br><b>Washington Park</b> |  | 24d. LOCATION (City, town, or county) (State)<br><b>St. Louis County MO</b> |  |
| DATE REC'D BY LOCAL REG.<br><b>JUN 29 1959</b>              |  | REGISTRAR'S SIGNATURE<br><b>Earl Smith, M.D.</b> |  | 25. FUNERAL DIRECTOR'S SIGNATURE<br><b>Boyd Bros</b>         |  | ADDRESS<br><b>3706 Finney Ave</b>   |  |

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 *Henry C. Williams*.....

Licensed Embalmer No. *497*

P. O. Address *1205 W*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.  
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.