URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS OCT 5 1959

59-034462

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 8783

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Homer G. Phillips
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 4539 Page
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Winston; Middle: ; Last: Warren
4. DATE OF DEATH: Month 9; Day 21; Year 59
5. SEX: Male
6. COLOR OR RACE: Negro
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 10-15-1905
9. AGE (last birthday): 53
IF UNDER 1 YEAR: Months ; Days
IF UNDER 24 HR: Hours ; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck driver
10b. KIND OF BUSINESS OR INDUSTRY: Klipsch Coal Co.
11. BIRTHPLACE (City and state or country): St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: Calvin Warren
13b. MOTHER'S MAIDEN NAME: Annie Crawford
14. NAME OF HUSBAND OR WIFE: Bessie Warren
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): WW II
16. SOCIAL SECURITY NO.: 488-18-1797
17. INFORMANT: Bessie Warren Address: 4539 Page Blvd.

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): Hypertensive Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH: Undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 443x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Hypertensive Encephalopathy, Bronchopneumonia

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ 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

21. I attended the deceased from 9-5-59, to 9-21-59 and last saw him alive on 9-21-59
Death occurred at 9:10 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Marvin Rosecan (Degree or title) M. D.
22b. ADDRESS: 2601 N. Whittier St.
22c. DATE SIGNED: 9-22-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 9-28-59
23c. NAME OF CEMETERY OR CREMATORY: National Cemetery
23d. LOCATION (City, town, or county) (State): Jefferson Barracks, Missouri

24. FUNERAL DIRECTOR: Russell Und., Co. ADDRESS: 2732 Pine Street
25. DATE RECD. BY LOCAL REG.: SEP 23 '59
26. REGISTRAR'S SIGNATURE: Noal Smith M.D. MB

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by n

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed James A Carter

Licensed Embalmer No. 4681

P. O. Address St. Lau

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