

# MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 15 1960

=60-004388

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 287

INDEXED

<b>1. PLACE OF DEATH</b> a. COUNTY <u>St. Louis</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clayton</u>	Length of stay in 1b <u>D.O.A.</u>	c. CITY OR TOWN <u>Breckenridge Hills</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis Co. Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3347 Sims Ave.</u>

<b>3. NAME OF DECEASED</b> (Type or print) First <u>Clara</u> Middle <u>Jean</u> Last <u>Warren</u>	<b>4. DATE OF DEATH</b> Month <u>January</u> Day <u>26</u> Year <u>1960</u>
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<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>6-26-18</u>	<b>9. AGE (last birthday)</b> <u>41</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Home</u>	<b>11. BIRTHPLACE</b> (City and state or country) <u>St. Clair, Missouri</u>	<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>
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<b>13a. FATHER'S NAME</b> <u>Joseph McKinney</u>	<b>13b. MOTHER'S MAIDEN NAME</b> <u>Maude Johnson</u>	<b>14. NAME OF HUSBAND OR WIFE</b> <u>Arthur J. Warren</u>
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	<b>16. SOCIAL SECURITY NO.</b> <u>Unknown</u>	<b>17. INFORMANT</b> Address <u>Arthur J. Warren, 3347 Sims Ave.</u>
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ch. Cerebral Infarction</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	INTERVAL BETWEEN ONSET AND DEATH
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<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH</b> but not related to the terminal disease condition given in PART I (a)		<b>PART III. If deceased was female</b> was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown	
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/>	<b>SUICIDE</b> <input type="checkbox"/>	<b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)
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<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m.	<b>Month, Day, Year</b>
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<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>	<b>COUNTY</b>	<b>STATE</b>
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21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her alive on \_\_\_\_\_  
 Death occurred at 6:44 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

<b>21a. SIGNATURE</b> (Degree or title) <u>John C. Murphy MD Asst. Health Commissioner</u>	<b>21b. ADDRESS</b> <u>801 S. Brentwood Clayton, Mo.</u>	<b>21c. DATE SIGNED</b> <u>2-4-60</u>
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<b>23. BURIAL CREMATION</b>	<b>23b. DATE</b> <u>1-29-1960</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Warren Cemetery</u>	<b>23d. LOCATION</b> (City, town, or county) (State) <u>Tea, Missouri</u>
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<b>24. FUNERAL DIRECTOR</b> <u>Baumann Bros. Inc. Overland, Mo.</u>	<b>ADDRESS</b> <u>2504 Woodson Rd.</u>	<b>25. DATE RECD. BY LOCAL REG.</b> <u>1-28-60</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>John C. Murphy M.D.</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

REMOVAL

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed David C. Gibb

Licensed Embalmer No. 3457

P. O. Address Overland

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.