

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

12532 - 62-048834  
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12532

FILED JAN 10 1963

VS 300  
Rev. 4/59

1

2 2201

3

4 0

5 1

6

7 0

8 2

9

10

11

12 69-0

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

|   |  |   |  |   |  |   |  |  |                                     |  |  |
|---|--|---|--|---|--|---|--|--|-------------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>St. Louis</u>                     |  | Length of stay in 1b<br><u>1 Mo-8 days</u>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY |  | c. CITY OR TOWN <u>St. Louis</u>   |                                     | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION<br><u>St. Louis-Little Rock Hospital, Inc.</u>  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                      |  | d. STREET ADDRESS (If outside, give location)<br><u>2534 Dodier</u>   |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  |  |  |                                     |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Roscoe</u> Middle <u>Hollie</u> Last <u>Warden</u>  |  |   | 4. DATE OF DEATH<br>Month <u>December</u> Day <u>26</u> Year <u>1962</u> |   |  |   |  |  |                                     |  |  |
| 5. SEX<br><u>Male</u>   |  | 6. COLOR OR RACE<br><u>White</u>  |  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>6-15-1897</u>  |  | 9. AGE (last birthday)<br><u>65</u>  |                                     | IF UNDER 1 YEAR<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Pensr. Mail Handler</u>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Railroad</u>  |  | 11. BIRTHPLACE (City and state or country)<br><u>Dent Co., Mo.</u>  |  | 12. CITIZEN OF WHAT COUNTRY<br><u>U.S.</u>   |                                     |  |  |
| 13a. FATHER'S NAME<br><u>Steve Warden</u>   |  |   |  | 13b. MOTHER'S MAIDEN NAME<br><u>Emma Hooden Paugh</u>   |  |   |  | 14. NAME OF HUSBAND OR WIFE<br><u>Clara Mae Warden</u>   |                                     |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>   |  |   |  | 16. SOCIAL SECURITY NO.<br><u>Unknown</u>   |  | 17. INFORMANT<br>Address<br><u>Vernon Warden, 8214 Minnesota</u>  |  |  |                                     |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cancer of Lung -</u>   |  |   |  |   |  |   |  |  |                                     | INTERVAL BETWEEN ONSET AND DEATH   |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____   |  |   |  |   |  |   |  |  |                                     |  |  |
| DUE TO (c) _____ <u>163x</u>  |  |   |  |   |  |   |  |  |                                     |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)   |  |   |  |   |  |   |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |                                     |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____ a.m. _____ p.m.   |  | Month, Day, Year  |  |   |  |   |  |  |                                     |  |  |
| 20d. INJURY OCCURRED WHILE AT WORK <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 <u>Nov. 19, 1962</u> to <u>Dec. 26, 1962</u> and last saw <u>him</u> alive on <u>Dec. 26, 1962</u><br>- Death occurred at <u>10-45 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |  |   |  |   |  |  |                                     |  |  |
| 22a. SIGNATURE<br><u>Charles Thomas, M.D.</u> (Degree or title)   |  |   |  |   |  | 22b. ADDRESS<br><u>1755 S. Grand Blvd.</u>  |  |  | 22c. DATE SIGNED<br><u>12-26-62</u> |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u>   |  | 23b. DATE<br><u>12-29-62</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Local Cemetery</u>   |  | 23d. LOCATION (City, town, or county)<br><u>Salem, Mo.</u>  |  | (State)  |                                     |  |  |
| 24. FUNERAL DIRECTOR<br><u>Spencer Funeral Home, Salem, Mo.</u> ADDRESS   |  |   |  | 25. DATE RECD. BY LOCAL REG.<br><u>DEC 28 1962</u>  |  | 26. REGISTRAR'S SIGNATURE<br><u>Paul Smith, M.D.</u>  |  |  |                                     |  |  |

USE BLACK INK OR TYPEWRITER RIBBON

JAN 10 1963

MISSOURI

**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

*Stanley H. Arison*

Licensed Embalmer No.

*4193*

P. O. Address

*St. Louis*

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.