

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-046176

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11739

DO NOT WRITE ON THIS STUB AMENDED

VS 300	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF
Rev. 4/59						
1						
2 <i>216</i>						
3						
4 <i>0</i>						
5 <i>1</i>						
6						
7 <i>1</i>						
8 <i>2</i>						
9						
10						
11						
12 <i>90-0</i>						
13						
<i>90</i>						

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 22 Yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3298a Gravois				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3298a Gravois				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARLEY Middle DAVID Last WARREN						4. DATE OF DEATH Month 11 Day 26 Year 63					
5. SEX Male		6. COLOR OR RACE White		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 2/16/16		9. AGE (last birthday) 47		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Interviewer				10b. KIND OF BUSINESS OR INDUSTRY State Employment		11. BIRTHPLACE (City and state or country) Arkansas		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13a. FATHER'S NAME Harley Warren				13b. MOTHER'S MAIDEN NAME Lillian				14. NAME OF HUSBAND OR WIFE Mamie Warren			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of servt) No						16. SOCIAL SECURITY NO.		17. INFORMANT Address Mamie Warren, 3298a Gravois			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma Left Colon										INTERVAL BETWEEN ONSET AND DEATH 6 mo.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										DUE TO (b) 153-2	
DUE TO (c)											
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
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 6:05 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 8-16-63 to 11-26-63 and last saw ^{her} him alive on 11-24-63 Death occurred at 6:05 P. m on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE <i>H.L. Tomlinson</i> (Degree or title) MD						22b. ADDRESS 508 N. Grand St. Louis Mo.			22c. DATE SIGNED 11-27-63 (State)		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 11/29/63		23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery		23d. LOCATION (City, town, or county) St. Louis Co., Mo. (State)					
24. FUNERAL DIRECTOR McLAUGHLIN'S, 2301 Lafayette ADDRESS				25. DATE RECD. BY LOCAL REG. NOV 27 1963		26. REGISTRAR'S SIGNATURE <i>Loard Smith, M.D.</i>					

EMBALM-001

STATEMENT BY LICENSED EMBALMER

6 P
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0 - 1

0 - 09

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 A. G. Farris

Licensed Embalmer No. 3384

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.