MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

3457

1. PLACE OF DEATH

County St. Louis — Registration District No. 1123 — File No.

Township Carondelet — Primary Registration District No. 6248 B — Registered No. 25

City Jefferson Barracks Mo. (No. U.S. Veterans' Hospital, Jefferson Brks, Mo. St. Ward)

2. FULL NAME William A. Warden. — I. R. Wagner. M.D. — I. R. Wagner M.D.

(a) Residence. No. Richland, Mo. St., Ward. Medical Officer In Charge.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred un yrs. kn mos. own ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White.	Widower.

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs. William A Warden (Deceased)

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 30, 1893 1893

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ... min.
	34	4	15	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer) Unavailable.

(c) Name of employer Unavailable.

9. BIRTHPLACE (CITY OR TOWN) Unavailable.
(STATE OR COUNTRY) Nebraska.

PARENTS

10. NAME OF FATHER Unavailable.

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unavailable.
(STATE OR COUNTRY) Unavailable.

12. MAIDEN NAME OF MOTHER Unavailable.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unavailable.
(STATE OR COUNTRY) Unavailable.

14. INFORMANT F. C. Walsh
(Address) F. C. Walsh. Medical Officer. U.S. Veterans' Hospital, Jefferson Barracks Mo.

15. FILED Jan. 15, 1929 L. C. Obrock M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 15, 1929 19

17. I HEREBY CERTIFY, That I attended deceased from Jan. 12, 1929, 19, to Jan. 15, 1929, 19, that I last saw him alive on Jan. 15, 1929, 19, and that death occurred, on the date stated above, at 10:45 AM. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Broncho-pneumonia.

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Valvular Heart Disease. Cardiac decompensation.

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED?

IF NOT AT PLACE OF DEATH? Unknown.

DID AN OPERATION PRECEDE DEATH? No. DATE OF

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? Physical, Laboratory findings.

(Signed) H. Freed, M. D

, 19 (Address) H. Freed, Medical Officer. U.S. Veterans' Hospital, Jefferson Barracks Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Richland Mo. — DATE OF BURIAL: Jan 15 1929

20. UNDERTAKER: C. Hoffmeister & Co. — ADDRESS: 7814 S Broadway

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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

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Township Carondelet — Primary Registration District No. 6248 B — Registered No. 25

City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME William A. Warden

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
M	W	Wid

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 30 - 1893

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	35	4	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED Oct. 3 1929 L. C. Obrock M.D.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 15 1929

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19....., that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) ....., M. D

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied ... be stated EXACTLY. ... should state CAUSE OF DEATH in plain terms, so that it may ... ment of ... important.

REGISTRARS NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY L...

S-3457