

No. 2
1-4-41
-17-39
X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **33682**
Registrar's No. **8640**

DIED NOV 24 1941 791

Registration District No. Primary Registration District No.

1. PLACE OF DEATH:

(a) County **ST. LOUIS MO**
(b) City or town **ST. LOUIS MO**
(c) Name of hospital or institution **8622 GOODFELLOW / AV.**
(d) Length of stay: In hospital or institution **LIFE**
In this community **LIFE**

3. (a) PRINT FULL NAME **ELIZABETH WARNICK**

3. (b) If veteran, name war **NONE** 3. (c) Social Security No. **NONE**

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **WIDOWED**

6. (b) Name of husband or wife **JAMES WARNICK DECEASED** 6. (c) Age of husband or wife at death **92**

7. Birth date of deceased **SEP. 9TH 1861**

8. AGE: Years **80** Months **1** Days **19** If less than one day **—** hr. **—** min.

9. Birthplace **ST. LOUIS MO**

10. Usual occupation **HOUSE WORK AT HOME**

11. Industry or business **HENRY NIEMANN**

12. Name **GERMANY**

13. Birthplace **GERMANY**

14. Maiden name **WILHELMINA HARTMANN**

15. Birthplace **GERMANY**

16. (a) Informant **Mrs. J. Hemmelen**

(b) Address **8622 Goodfellow**

17. (a) **BURIAL** (b) Date thereof **OCT 31-41**

(c) Place: burial or cremation **CALVARY CEM.**

18. (a) Signature of funeral director **W. H. Haggard**

(b) Address **1827 Haggard Str**

19. (a) **OCT 20 1941** (b) **J. F. Bredebeck**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **000**
(c) City or town **ST. LOUIS**
(d) Street No. **8622 GOODFELLOW AV.**
(e) Citizen of foreign country? **—** (Yes or No) **0**
If yes, name country: **—**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **OCT** day **28TH** year **1941** hour **1:35** minute **P.** M.

21. I hereby certify that I attended the deceased from **Jan. 1941** to **10/28/41**

that I last saw her alive on **10/28/41** and that death occurred on the date and hour stated above.

Immediate cause of death **Ch. Hypertension** Duration **1yr**

Due to **93**

Due to **93**

Other conditions **Senility** (Include pregnancy within 3 months of death)

Major findings: Of operations **none** **93**

Of autopsy **none**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **no**

(b) Date of occurrence **—**

(c) Where did injury occur? **—** (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **—**

While at work? **—** (Specify type of place) (e) Means of injury **—**

23. Signature **H. J. Stein** (M. D. or other) **MD**

Address **6807 W. Lorraine** Date signed **10/28/41**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

G. W. Wilkinson

Licensed Embalmer No..... *3575*

P. O. Address.....

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 this body is not embalmed, fact should be so stated above.