

FILED FEB 4 1944 318

State File No. 1125
Registrar's No. 887

Registration District No. Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County.....
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Mo. Pacific Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME **Julius W. Warren**
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Evaline Warren** 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased **Mar. 6 1879**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
64 10 21 hr. min.

9. Birthplace **St. Louis Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Engineer**

11. Industry or business **Terminal R.R.**

12. Name **John B. Warren**

13. Birthplace **Mo.**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **H. J. Carrico**

(b) Address **5464 Arlington Ave**

17. (a) **Burial** (b) Date thereof **1-29-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Lebanon Cem. Drehmann-Harral**

18. (a) Signature of funeral director **J. F. Bideck**

(b) Address **21905 Union Blvd.**

19. (a) **28 704** (b) **J. F. Bideck**
(Date received local registrar's certificate) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **17**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **4931 P.N. Unions Blvd**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan.** day **27**
year **1944** hour **12** minute **10** A.M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....;
that I last saw him..... alive on....., 19.....,
and that death occurred on the date and hour stated above.

Immediate cause of death **Hemorrhage due to Gun shot wound in Head Self Inflicted at his Home**
Due to **4931 Union Blvd on Jan 17-1944 at about 8:30 P.M.**

Due to.....
Other conditions.....
(Include pregnancy within 3 months of death) **164**

Major findings:
Of operations.....
Of autopsy.....
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) **Suicide**
(b) Date of occurrence **1-17-44**
(c) Where did injury occur? **At Home**
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home

While at work?..... (Specify type of place)
(e) Means of injury **Gun**
23. Signature **James J. Johnson** (M.D. or other)
Address **11309 1/2 Clark** Date signed **1/28/44**

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..... *Albert R. Thompson*

Licensed Embalmer No. *4239*

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