

FILED JAN 24 1944

State File No. _____

Registration District No. 317

Primary Registration District No. 3063

Registrar's No. 154

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis County Hospital
(If not in hospital or institution, write street number or location) 0
(d) Length of stay: In hospital or institution 2 days
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 96
(c) City or town Webster Groves 7
(If outside city or town limits, write "RURAL") 4
(d) Street No. 712 Dale
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Ann Warner

3. (b) If veteran, name war. -- 3. (c) Social Security No. --

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, Single

6. (b) Name of husband or wife. ---- 6. (c) Age of husband or wife if alive. -- years

7. Birth date of deceased 1-10-1890
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
54 0 9 hr. min.

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

10. Usual occupation Unemployed

11. Industry or business --

12. Name George K. Warner

13. Birthplace Unknown Ala.
(City, town, or county) (State or foreign country)

14. Maiden name Helen Ewing

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

16. (a) Informant Warner

(b) Address 5-926 Enright

17. (a) Burial (b) Date thereof 1-22-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellfontaine

18. (a) Signature of funeral director Alfred

(b) Address 617 1/2 Elm

19. (a) JAN 20 1944 (b) L. G. Mc Gowan, M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1-19-44 day _____
year _____ hour 1:15 minute _____ P. M.

21. I hereby certify that I attended the deceased from 1-17-44, 19____, to 1-19-44, 19____,
that I last saw h. er alive on 1-19-44, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death Subacute yellow atrophy of liver

Duration

? 3 wks.

Due to _____

Due to _____

Other conditions Pulmonary edema
(Include pregnancy within 3 months of death)

Major findings: Of operations none performed

Of autopsy Subacute yellow atrophy of liver

PHYSICIAN

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) _____

(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)
(a) Means of injury _____

23. Signature James G. Owen, M.D. (M. D. or other)

Address 601 Blyford Blvd, Clayton Date signed 1-19-44

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

Wp6

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 *jos. E Mc Cullough*

Licensed Embalmer No. *2460*

P. O. Address *6175 Pellme*

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.