

FILED JAN 31 1944

State File No. _____

Registration District No. 374

Primary Registration District No. 6076

Registrar's No. 166

1. PLACE OF DEATH:

(a) County St. Louis Mo.
(b) City or town Rock Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Robert Koch Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 720 days
(Specify whether
In this community 720 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1442 N-14th St - near
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME JAMES WARREN

3. (b) If veteran, name war _____ 3. (c) Social Security No. no link

4. Sex Male 5. Color or race negro 6. (a) Single, widowed, divorced, married
6. (b) Name of husband or wife SINESTER WILLIS WARREN 6. (c) Age of husband or wife if alive 28 years
7. Birth date of deceased Feb 23 1914
(Month) (Day) (Year)

8. AGE: Years 29 Months 10 Days 27 If less than one day hr. _____ min. _____

9. Birthplace Carroll Ill (City, town, or county) (State or foreign country)

10. Usual occupation Labourer

11. Industry or business _____

12. Name BURTON WARREN

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

14. Maiden name VENOLA AVERY

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

16. (a) Informant P. Venola Taylor

(b) Address 944 1/2 Broadway St

17. (a) Burial (b) Date thereof 7-19-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cemetery

18. (a) Signature of funeral director Ornie Love

(b) Address 3105 Washington Blvd

19. (a) JAN 26 1944 (b) E. J. McRaven, Jr
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 19th year 1944 hour 12 minute 05 A.M.

21. I hereby certify that I attended the deceased from Jan 24th 1944, to Jan 19th 1944
that I last saw him alive on Jan 18th 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Relapsed Pul. tuberculosis Duration 3 yrs?

Due to Cerebral accident 5 mch 3

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy 138-1

Duration

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) Means of injury _____

23. Signature Ed M. Umble (M. D. or other) _____

Address Robert Koch Hospital Date signed 1-19-44

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

16
0
0

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 Arthur L. Hilliard

Licensed Embalmer No. 4221

P. O. Address 4219th E. Mayfield

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.