

FILED JUN 4 1945
Registration District No. **577**

Primary Registration District No. **6076**

Registrar's No. **1003**

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

1. PLACE OF DEATH:

(a) County **ST. LOUIS**

(b) City or town **PINE LAWN**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
6400 GROVE AVE
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)

In this community **35 YEARS**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **ST. LOUIS**

(c) City or town **PINE LAWN**
(If outside city or town limits, write "RURAL")

(d) Street No. **6400 GROVE AVE**
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **SELENA M. WARNKE**

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **24** year **1945** hour **10** minute **20 AM**

21. I hereby certify that I attended the deceased from **January 4** 19**45** to **April 10** 19**45**
that I last saw her alive on **April 10** 19**45** and that death occurred on the date and hour stated above.

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

6. (b) Name of husband or wife **MICHAEL WARNKE** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **DEC 31 1865**
(Month) (Day) (Year)

Immediate cause of death **Stokes-Adams syndrome** Duration **1.5 yrs**

Due to **95a**

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

8. AGE: Years **79** Months **3** Days **23** If less than one day _____ hr. _____ min.

9. Birthplace **LOUISIANA - MO**
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSE WIFE**

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER {

11. Industry or business _____

12. Name **JOHN FLETCHER**

13. Birthplace **Unknown** (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 **Mrs. Wigney Huntington**
(b) Address **6400 Grove Ave**

17. (a) **BURIAL** (b) Date thereof **4-27-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **L. G. Tanner**
(b) Address **6107 Natural Bridge Rd**

19. (a) **APR 25 1945** (b) **E. B. H. Pantan**
(Date received local health officer) (Registrar's signature)

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? _____

(Specify type of place) _____

(e) Means of injury _____

23. Signature **P. C. Sinclair** M.D. or other _____
Address **3718 Jennings Road** Date signed **April 24 1945**

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..... *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.