

FILED JUL 9 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

21821

State File No. ....

318

1003

Registrar's No. 5572

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. \_\_\_\_\_ PRIMARY REG. DIST. NO. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital		d. STREET ADDRESS (If rural, give location) 2904 Clark Ave.	
3. NAME OF DECEASED (Type or Print) Reverend Ralph W. Warner S.J.		4. DATE OF DEATH (Month) (Day) (Year) June 27, 1949	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) S.	8. DATE OF BIRTH Feb. 2, 1909
9. AGE (In years last birthday) 40		10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis, Mo.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Catholic Priest		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Ralph Warner		13b. MOTHER'S MAIDEN NAME Agnes Dean	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Rev. Fred L. Zimmerman S.J., 2904	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Hypertensive C. &amp; R. Renal disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 1/2 yrs</i>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b)  DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <i>131</i>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <i>442X</i>

22. I hereby certify that I attended the deceased from *3-15-1948*, to *6-27-1949*, that I last saw the deceased alive on *6-27-1949*, and that death occurred at *6:27 p.m.*, from the causes and on the date stated above.

23a. SIGNATURE <i>Carl Stein M.D.</i>	(Degree or title)	23b. ADDRESS <i>Steinhardt Bldg.</i>	23c. DATE SIGNED <i>6-28-49</i>
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24b. DATE <i>June 30, 1949</i>	24c. NAME OF CEMETERY OR CREMATORY <i>St. Stanislaus Seminary, Florissant, Mo.</i>	24d. LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REG. <i>JUN 28 1949</i>	REGISTRAR'S SIGNATURE <i>J. B. Casator</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur J. Donnelly</i>	ADDRESS <i>349 Lindell Blvd.</i>

(Licensed Embalmer's Statement on Reverse Side)

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

*Carl A. Newberg  
Hudson River, N.Y.*

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

*W. H. Van Matre*

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. *2825*

P. O. Address *4340 Lafayette*

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.