

FILED MAR 4 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 6857

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. 1003 Registrar's No. 1607

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Barnes Hospital,		d. STREET ADDRESS (If rural, give location) 5 5926 Enright	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) Robert	b. (Middle) Horn	c. (Last) Warner	(Month) Feb.	(Day) 16,	(Year) 1950
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov. 25, 1889	9. AGE (In years last birthday) 60	IF UNDER 1 YEAR Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Federal Govt.		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME George K. Warner	13b. MOTHER'S MAIDEN NAME Helen Ewing	14. NAME OF HUSBAND OR WIFE Hope D.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. --	17. INFORMANT'S SIGNATURE OR NAME Hope D. Warner--5926 Enright

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, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute myocardial infarction		INTERVAL BETWEEN ONSET AND DEATH 6 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis (Coronary arteries)		
	DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetic mellitus		

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) H201
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR

22. I hereby certify that I attended the deceased from Feb. 10, 1950, to Feb. 16, 1950, that I last saw the deceased alive on Feb. 16, 1950, and that death occurred at 3:35 P.m., from the causes and on the date stated above.

23a. SIGNATURE Robert V. Grevchman M.D.	23b. ADDRESS Barnes Hospital,	23c. DATE SIGNED 2/16/50
24a. BURIAL (CREMATION, REMOVAL) (Specify) Cremation	24b. DATE 2/20/50	24c. NAME OF CEMETERY OR CREMATORY Missouri Crematory
24d. LOCATION (City, town, or county) (State) St. Louis, Missouri	25. FUNERAL DIRECTOR'S SIGNATURE Wacker - Helderle	
DATE REC'D BY LOCAL REG. FEB 18 1950	REGISTRAR'S SIGNATURE J. B. Lusater	ADDRESS 3634 Gravois

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

**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.

Student .....  
Student Embalmer

Signed.....

*Frank J. Hand*

Licensed Embalmer No. ....

*19675*

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.