

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31931

State File No.

Registrar's No. 8344

FILED OCT 10 1951

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BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		State File No.	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give town) <u>ST. LOUIS Mo</u>		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) <u>ST. LOUIS</u>		2269	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>FIRMIN DESLOGE Hosp.</u>				d. STREET ADDRESS (If rural, give location) <u>26 3620 N. 9th ST.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>BEULAH</u> b. (Middle) <u>-</u> c. (Last) <u>WARDEN</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 20 1951</u>				
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>MAY 11 1902</u>	9. AGE (In years last birthday) <u>49</u>	IF UNDER 1 YEAR Months	IF UNDER 11 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work dominating most of working life, even if retired) <u>HOUSE WORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>TENNESSEE</u>		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME <u>JOHN OGG</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>SAM WARDEN (DECEASED)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>CLIFFORD WARDEN 3620 N. 9th</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) <u>Lower nephron nephrosis</u> <u>transfusion reaction incident to treatment for bilateral tubo-ovarian abscesses following irradiation therapy for carcinoma of cervix</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>				INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>5 years.</u>	
19a. DATE OF OPERATION <u>9-10-51</u>		19b. MAJOR FINDINGS OF OPERATION <u>Bilateral tubo-ovarian abscesses.</u>				20. AUTOPSY? YES <input checked="" 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)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>171X</u>			
22. I hereby certify that I attended the deceased from <u>9-8-51</u> to <u>9-20-51</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>9-20-51</u> , 19 <u>51</u> , and that death occurred at <u>4:33A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Glenn E. Dalby M.D.</u>				23b. ADDRESS <u>1325 S. Grand, St. Louis 4, Mo.</u>		23c. DATE SIGNED <u>9-20-51</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>SEPT. 24 1951</u>		24c. NAME OF CEMETERY OR CREMATORY <u>WALKER CHAPEL CEM.</u>		24d. LOCATION (City, town, or county) (State) <u>DRESDEN TENNESSEE</u>	
DATE REC'D BY LOCAL REG. <u>SEP 21 1951</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Thomas Kutis 2906 Garrison</u>			

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 _____

working under my personal supervision.

Student Embalmer No.

Signed _____

Prof. Budde

Signed.....
Student Embalmer

Licensed Embalmer No. *3989*

P. O. Address *St. Louis, Mo.*

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.