

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35725**
9286

FILED NOV 2 1951

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY Madison	
b. CITY OR TOWN ST. LOUIS, MO.		c. CITY OR TOWN Granite City, 8120	
c. LENGTH OF STAY (In this place) 9 Days		d. STREET ADDRESS (If rural, give location) 2724 Marshall Ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL			

3. NAME OF DECEASED (Type or Print) a. (First) Barbara	b. (Middle) A.	c. (Last) Warren	4. DATE OF DEATH (Month) (Day) (Year) 10 19 51
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 14, 1929	9. AGE (In years last birthday) 22	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HR. Hours	IF UNDER 1 HR. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Billing Dept.	10b. KIND OF BUSINESS* OR INDUSTRY Nesco	11. BIRTHPLACE (State or foreign country) Granite City, Illinois/	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME Daniel Boone	13b. MOTHER'S MAIDEN NAME Stella Dennis	14. NAME OF HUSBAND OR WIFE Jesse Warren
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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. 357-24-0086	17. INFORMANT'S SIGNATURE OR NAME _____ ADDRESS _____
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Post-operative Pulmonary Edema		5 hours
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Bronchæctasis- Bilateral lower lobe DUE TO (c) _____		15 Years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION 10-19-51	19b. MAJOR FINDINGS OF OPERATION Bronchæctasis- right middle and lower lobe	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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? 526X

22. I hereby certify that I attended the deceased from **10-10, 1951**, to **10-19, 1951**, that I last saw the deceased alive on **10-19, 1951**, and that death occurred at **7:30p m.**, from the causes and on the date stated above.

23a. SIGNATURE Richard M. Peter (Degree or title) M.D.	23b. ADDRESS BARNES HOSPITAL	23c. DATE SIGNED _____
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Oct. 19, 51	24c. NAME OF CEMETERY OR CREMATORY St. Johns	24d. LOCATION (City, town, or county) (State) Granite City, Illinois
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DATE-REC'D BY LOCAL REG. Oct 22 1951	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS Granite City
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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..... *Charles E. Mercer*

Signed.....
Student Embalmer

Licensed Embalmer No. *2988*

P. O. Address. *Grant City, Ill.*

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.