

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **45618**  
Registrar's No. **12254**

1-19-54  
FILED JAN 19 1954

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ST. LOUIS MO.</b>                 |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <b>ARKANSAS</b> b. COUNTY _____ |  |
| b. CITY OR TOWN <b>ST. LOUIS, MO.</b>                               |  | c. CITY OR TOWN <b>FAYETTEVILLE</b>   |  |
| c. LENGTH OF STAY (in this place) <b>13 1/2 DAYS</b>                |  | 80308   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. LOUIS CHILDREN'S</b> |  | d. STREET ADDRESS (If rural, give location) <b>434 HOLLY STREET</b>   |  |

|   |  |  |   |  |  |
|---|--|--|---|--|--|
| 3. NAME OF DECEASED<br>(Type or Print) <b>FAYE N.M.N. WARREN</b>                                  |  |  | 4. DATE OF DEATH (Month) (Day) (Year) <b>12-25-53</b> |  |  |
| 5. SEX <b>FEMALE</b>  |  | 6. COLOR OR RACE <b>WHITE</b>            |   | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>SINGLE</b>         |  |
| 8. DATE OF BIRTH <b>11-16-53</b>  |  | 9. AGE (In years last birthday) <b>1</b> |   | 10. IF UNDER 1 YEAR Days <b>1</b> Hours _____ Min. _____                     |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____ |  | 10b. KIND OF BUSINESS OR INDUSTRY _____  |   | 11. BIRTHPLACE (City and State or Foreign Country) <b>FAYETTEVILLE, ARK.</b> |  |
| 12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>   |  |  |   |  |  |

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 13a. FATHER'S NAME <b>B. DAVIS WARREN</b>                               |  | 13b. MOTHER'S MAIDEN NAME <b>MARY LOUISE GROSSE</b> |  | 14. NAME OF HUSBAND OR WIFE _____                |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____ |  | 16. SOCIAL SECURITY NO. _____                       |  | 17. INFORMANT'S SIGNATURE OR NAME <b>J. EGAN</b> |  |
|   |  |   |  | ADDRESS <b>500 So Kings Highway</b>              |  |

|  |  |   |  |  |                                  |
|--|--|---|--|--|----------------------------------|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)  |  | MEDICAL CERTIFICATION   |  |  | INTERVAL BETWEEN ONSET AND DEATH |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>HT (Heart) failure</b>   |  | DUPLICATE   |  |  |                                  |
| *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. |  | ANTECEDENT CAUSES   |  |  |                                  |
|  |  | Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.                                  |  |  |                                  |
|  |  | DUE TO (b) <b>Abnormally</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) _____ |   |  |
| 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? <b>776X</b>                |   |  |

22. I hereby certify that I attended the deceased from **12-11**, 1953, to **12-25**, 1953, that I last saw the deceased alive on **12-25**, 1953 and that death occurred at **5:10 A.M.**, from the causes and on the date stated above.

|  |  |                           |  |  |  |   |  |
|--|--|---------------------------|--|--|--|---|--|
| 23a. SIGNATURE <b>John E. Newey, M.D.</b>                    |  | (Degree or title)         |  | 23b. ADDRESS <b>Childrens Hospital</b>                       |  | 23c. DATE SIGNED <b>12-26-53</b>  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremination</b> |  | 24b. DATE <b>12-26-53</b> |  | 24c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Crematory</b> |  | 24d. LOCATION (City, town, or county) (State) <b>St. Louis, County, MO.</b> |  |

|   |  |   |  |   |  |                                 |  |
|---|--|---|--|---|--|---------------------------------|--|
| DATE REC'D BY LOCAL REG. <b>DEC 28 1953</b> |  | REGISTRAR'S SIGNATURE <b>Carl Smith</b> |  | 25. FUNERAL DIRECTOR'S SIGNATURE <b>Albert H. Hoppe</b> |  | ADDRESS <b>4700 Washington.</b> |  |
|---|--|---|--|---|--|---------------------------------|--|

(Licensed Embalmer's Statement on Reverse Side)

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 *Pro Embalmer*  
*Q. J. Smith*

Licensed Embalmer No. ....

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.