

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24172**
Registrar's No. **5657**

FILED AUG 2 - 1955

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Firmin Desloge Hospital		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) a. (First) WARREN b. (Middle) Wallace c. (Last) NULL		4. DATE OF DEATH (Month) (Day) (Year) JUNE 29 55	
5. SEX m.	6. COLOR OR RACE w	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH May 19, 1923
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 32 IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (City and State or Foreign Country) DeSoto, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Charles Null		13b. MOTHER'S MAIDEN NAME Maude Unknown	14. NAME OF HUSBAND OR WIFE Marie
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknowns) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 334-14-2281	17. INFORMANT'S SIGNATURE OR NAME Marie Null, 457 Eichelberger ADDRESS
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CARCINOMA OF LUNG ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. ? METASTASIS TO BRAIN 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 6-9-55		19b. MAJOR FINDINGS OF OPERATION BRONCHOSCOPY NEG.	
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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 163x			
22. I hereby certify that I attended the deceased from 6-7-55 , 1955 , to 6-29 , 1955 , that I last saw the deceased alive on 6-29 , 1955 , and that death occurred at 8:15P m., from the causes and on the date stated above.			
23a. SIGNATURE J. R. Weber (Degree or title) M.D.		23b. ADDRESS 1215 Moonland Dr.	
23c. DATE SIGNED 6-29-55			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 6-21-55	
24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) Vandalia, Ill.	
DATE REC'D BY LOCAL REG. JUN 30 1955		REGISTRAR'S SIGNATURE J. C. Smith M.D.	
25. FUNERAL DIRECTOR'S SIGNATURE Calcaterra Funeral Home ADDRESS 5140 Daggett			

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.....
Signature of Student Embalmer

Signed..... *J. W. Wilkins*

Licensed Embalmer No. *35*

P. O. Address..... *N. Lane*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.