

STANDARD CERTIFICATE OF DEATH

46444
STATE FILE NUMBER
12090

FILED DEC 30 1957

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

S. 300
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 4045a Shaw		d. STREET ADDRESS (If outside, give location) 4045a Shaw	
3. NAME OF DECEASED (Type or print) First Roy Middle Wells Last Varnum		4. DATE OF DEATH Dec. 14th. 1957	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-18-1888
9. AGE (In years last birthday) 69		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales-manager	11. BIRTHPLACE (City and state or country) Michigan
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Fremont Varnum	13b. MOTHER'S MAIDEN NAME Elizabeth Horrell
14. NAME OF HUSBAND OR WIFE Eleanor Varnum		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. 294-05-2467
17. INFORMANT Address Eleanor Varnum 4045a Shaw		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Arteriosclerotic Coronary Thrombosis DUE TO (c) 720-1	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Congestive Heart Failure, Chronic Bronchitis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 1955 to 12-14-57 and last saw him alive on 11-25-57 Death occurred at 5.30 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Am Higgins, M.D.		22b. ADDRESS 634 N. Grand	
22c. DATE SIGNED 12-14-57		23a. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	
23b. DATE 12-17-1957		23c. LOCATION (City, town, or county) (State) St. Louis Missouri	
24. FUNERAL DIRECTOR ADDRESS Anthony Donnelly 3840 Lindell Blvd.		25. DATE RECD. BY LOCAL REG. DEC 16 57	
26. REGISTRAR'S SIGNATURE Carl Smith Mo -m 8 B			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

Dr. John Hammond
Mo. Theatre Bldg
2:30 P.M.

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 *Francis Williamson*

Licensed Embalmer No. *3565*
P. O. Address *3840 Dendel*

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.