

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023506
STATE FILE NUMBER
2 5763

FILED JUL 1 1959

Registration District No. _____ Primary Registration District No. _____ Registrar No. _____

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|---|------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hosp. | | Length of stay in 1b 1 wk. | d. STREET ADDRESS (If outside, give location) 6406a West Park Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First ELIZABETH Middle MARY Last WARNER | | | 4. DATE OF DEATH Month June Day 16 Year 1959 |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Apr. 20, 1884 |
| 9. AGE (In years last birthday) 75 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Receptionist | 11. BIRTHPLACE (City and state or country) Jonesburg, Mo. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Receptionist | | 10b. KIND OF BUSINESS OR INDUSTRY Deaconess Hosp. | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13a. FATHER'S NAME Mathias Warner | | 13b. MOTHER'S MAIDEN NAME Mary Elizabeth Smith | 14. NAME OF HUSBAND OR WIFE None |
| 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. 490-26-7491 | 17. INFORMANT Address Matt Warner, 701 Robinson |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Embolus - Sudden Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Auricular Fibrillation DUE TO (c) Arteriosclerotic Heart Disease | | | INTERVAL BETWEEN ONSET AND DEATH Many years Many years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Carcinoma of ascending Colon - Colon resection 11³⁰am 6/15/59. | | | 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.) 420.0H | |
| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____ | | 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 1953 to June 16 1959 and last saw her alive on June 15, 1959 Death occurred at 6:15a on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE Donald A. Asto M.D. | | 22b. ADDRESS 4909 Rubenwood | 22c. DATE SIGNED 6-17-59 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 23b. DATE 6-18-59 | 23c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory |
| 23d. LOCATION (City, town, or county) St. Louis Co., Mo. | | (State) | |
| 24. FUNERAL DIRECTOR Parker-Aldrich, Webster Groves | | 25. DATE RECD. BY LOCAL REG. JUN 17 '59 | 26. REGISTRAR'S SIGNATURE Donald Smith, M.D. |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Leslie Welch*

Licensed Embalmer No. *4395*

P. O. Address *Holister Grove*

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.