RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59–031057
STATE FILE NUMBER

FILED WS SEP 8 1959

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 2347

1. PLACE OF DEATH
a. COUNTY: St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Valley Park — Length of stay in 1b: 10 days
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Moll Nursing Home — Inside Limits: Yes [X] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY: St. Louis
c. CITY OR TOWN: Kirkwood — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 473 Dickens — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: ALBERT Middle: Last: WARREN

4. DATE OF DEATH: Month Aug. Day 28 Year 1959

5. SEX: M
6. COLOR OR RACE: W
7. Married [X] Never Married [ ] Widowed [ ] Divorced [ ]
8. DATE OF BIRTH: 6-9-94
9. AGE (last birthday): 65
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HR: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Appraiser
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (City and state or country): Cleveland, Ohio
12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: Karel Warren
13b. MOTHER'S MAIDEN NAME: Rose Kalus
14. NAME OF HUSBAND OR WIFE: Hazel E. Warren

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 499-36-4771
17. INFORMANT: Virginia V. Rick, Cleveland, O. (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 day
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Generalized arteriosclerosis
DUE TO (c): Gangrene of 2 toes — 6 wks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Possible diabetes mellitus

PART III. If deceased was female was there a pregnancy in last 90 days? [ ] Yes [ ] No [ ] Unknown

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]
20a. ACCIDENT [ ] **SUICIDE** [ ] **HOMICIDE** [ ]
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. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 8/20/59, to 8/28/59 and last saw him alive on 8/27/59
Death occurred at 5:55 pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: [signature] (Degree or title): MD
22b. ADDRESS: Kirkwood, Mo.
22c. DATE SIGNED: 8/31/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE: 8-31-59
23c. NAME OF CEMETERY OR CREMATORY: Missouri Crematory
23d. LOCATION (City, town, or county) (State): St. Louis, Mo.

24. FUNERAL DIRECTOR ADDRESS: Parker-Aldrich, Webster Groves
25. DATE RECD. BY LOCAL REG.: 8-31-59
26. REGISTRAR'S SIGNATURE: John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Leslie Welch

Signature of Student Embalmer

Licensed Embalmer No. 4395

P. O. Address Webster Gro

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to con 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.