

# FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

FILED VS JUN 28 1960

-60-024203

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 132

1. PLACE OF DEATH a. COUNTY <b>ST. CHARLES</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>ST. LOUIS</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. CHARLES</b>		c. CITY OR TOWN <b>ST. LOUIS</b>	
Length of stay in 1b <b>1YR</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. JOSEPHS HOSP</b>		d. STREET ADDRESS (If outside, give location) <b>5525 CABANNE</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>ETHEL</b> Middle <b>WARREN</b> Last <b>WARREN</b>			4. DATE OF DEATH Month <b>JUNE</b> Day <b>23</b> Year <b>1960</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 21, 1915</b>	9. AGE (last birthday) <b>45</b>	IF UNDER 1 YEAR Months <b>2</b> Days <b>2</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WAITRESS</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RESTAURANT</b>		11. BIRTHPLACE (City and state or country) <b>TROY, Mo</b>		
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>JAMES SAMUEL BROYLES</b>		13b. MOTHER'S MAIDEN NAME <b>ROSIE ANN COX</b>		
14. NAME OF HUSBAND OR WIFE <b>RAYMOND WARREN (DIVORCED)</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO NOT</b>		16. SOCIAL SECURITY NO. <b>487-40-7078</b>		
17. INFORMANT <b>GLADYS GARNES, ST. CHARLES, Mo</b>		18. ADDRESS <b></b>		19. <b></b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2YR</b>
DUE TO (b) <b>Arteriosclerotic Heart Disease</b>		
DUE TO (c) <b></b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Cirrhosis of liver</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

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 <b></b> a.m. <b></b> p.m. <b></b>	Month, Day, Year <b></b>	

20d. INJURY OCCURRED WHILE AT WORK <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 <b>ST. CHARLES, Mo</b>	COUNTY <b></b>	STATE <b></b>
21. I attended the deceased from <b>June 21, 1960</b> to <b>June 23, 1960</b> and last saw her <b>alive</b> on <b>June 23, 1960</b>		Death occurred at <b>10:45 A</b> on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE <b>W H Poggenius</b> (Degree or title) <b>MD</b>		22b. ADDRESS <b>St Charles, Mo</b>		22c. DATE SIGNED <b>Jan 25, 1960</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>JUNE 25, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ALEXANDER CEMETERY</b>	23d. LOCATION (City, town, or county) <b>TROY, LINCOLN Co. Mo.</b>	(State) <b>Mo.</b>
24. FUNERAL DIRECTOR <b>C. L. PRINSTER</b>	ADDRESS <b>ST. CHARLES, Mo</b>	25. DATE RECD. BY LOCAL REG. <b>June 25-60</b>	26. REGISTRAR'S SIGNATURE <b>Marcella Wilson</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 \_\_\_\_\_

Signature of Student Embalmer

Signed

*Harold O Kessler*

Licensed Embalmer No. 4631

P. O. Address Wentzville

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.