

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-039729

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 3157 STATE FILE NUMBER

FILED NOV 15 1961

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clayton</u>		c. CITY OR TOWN <u>University City</u>	
Length of stay in 1b <u>MINS.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis County Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>7339 Northmoor Drive</u>	
Inside Limits Yes <input 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 <u>BARBARA</u> Middle <u>LOUISE</u> Last <u>WARREN</u>			4. DATE OF DEATH Month <u>November</u> Day <u>8</u> Year <u>1961</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 30, 1961</u>	9. AGE (last birthday) <u>0</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Leonard D. Warren, Jr.</u>		13b. MOTHER'S MAIDEN NAME <u>Barbara Louise Sweikert</u>		14. NAME OF HUSBAND OR WIFE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>L. D. Warren, Jr. -7339 Northmoor Drive</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:				INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Asphyxia</u>				<u>unknown</u> <u>approx 5-10</u> <u>minutes</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	<u>regurgitation + mucus plug</u>		
	DUE TO (c)	<u>strong clots</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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 <u></u> a.m. <u></u> p.m. <u></u> Month, Day, Year <u></u>					
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 COUNTY STATE	
21. I attended the deceased from <u>30 Aug 61</u> to <u>2 Nov 61</u> and last saw her/him alive on <u>12 Oct 61</u> Death occurred at <u>3:00 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Head Boles MD.</u>			22b. ADDRESS <u>35 N. Central Clayton</u>		22c. DATE SIGNED <u>9 Nov 61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>Nov. 9, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>C. R. Lupton & Sons-7233 Delmar Bly'd.</u>			25. DATE RECD. BY LOCAL REG. <u>11-9-61</u>		26. REGISTRAR'S SIGNATURE <u>John C. Murphy MD.</u>

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SHOULD READ

ITEM NO.

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.

not embalmed