

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-034212

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **8784**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED SEP 12 1963

VS 300 Rev. 4/59	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF	SHOULD READ
1							
2 <i>21</i>							
3							
4 <i>1</i>							
5 <i>0</i>							
6							
7 <i>1</i>							
8 <i>2</i>							
9							
10							
11							
12 <i>92-3</i>							
13							
<i>91</i>							

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>St. Louis,</b>		c. CITY OR TOWN <b>St. Louis</b>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Announced dead at Alexian Brothers Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>4426 Pennsylvania Ave.</b>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Alta Zoe Warren</b>			4. DATE OF DEATH Month Day Year <b>August 29, 1963</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7/1/1892</b>
9. AGE (last birthday) <b>71</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carlova Cosmetics Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired 3 Yrs.</b>	11. BIRTHPLACE (City and state or country) <b>Loup City, Nebraska</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>John M. Warren</b>	
13b. MOTHER'S MAIDEN NAME <b>Anna Betts</b>		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) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Lulu M. Rotermund</b>		Address <b>4426 Pennsylvania</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>Self-section, suffered when found in bed in home with plastic bag covering head on August 29<sup>th</sup> 1963.</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Suicide 979X</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 checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>See above</b>	
20c. TIME OF INJURY? Hour s.m. p.m. Month, Day, Year <b>8-29-63</b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home 15</b>		20f. CITY, TOWN, OR LOCATION <b>St. Louis, Mo</b>	
20g. COUNTY		20h. STATE	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <b>9:15 P.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Helen L. Taylor Coover</b>		22b. ADDRESS <b>1300 Clark Ave.</b>	
22c. DATE SIGNED <b>8-30-63</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>9/2/63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bellefontaine Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>
24. FUNERAL DIRECTOR <b>Gebken-Benz Mortuary</b> ADDRESS <b>2842 Meramec St. St. Louis 18, Missouri</b>		25. DATE RECD. BY LOCAL REG. <b>AUG 30 1963</b>	26. REGISTRAR'S SIGNATURE <b>Paul Smith M.D.</b>

USE BLACK INK OR TYPEWRITER RIBBON

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 Jan M. Sizemore

Licensed Embalmer No. 4343

P. O. Address St. Louis Mo.

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.