

DESD AUG 24 1939

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

26355  
Do not use this space.

1. PLACE OF DEATH

(a) County New Madrid Registration District No. 663  
(b) Township West Primary Registration District No. 5799 Registered No. \_\_\_\_\_  
(c) City Morehouse (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Lillie Warren Lillie Bell Warren  
(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)  
Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Robert Warren

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 3-13-1874

7. AGE YEARS 66 MONTHS 5 DAYS \_\_\_\_\_ If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
9. Industry or business in which work was done, as saw mill, bank, etc. House Work  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) Evansville (STATE OR COUNTRY) Indiana

FATHER 13. NAME Harpner

14. BIRTHPLACE (CITY OR TOWN) Indiana (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME \_\_\_\_\_

16. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY)

17. INFORMANT Ed Warren (ADDRESS) Morehouse Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Sikeston Mo. DATE 8/14/39

19. FUNERAL DIRECTOR (NAME) Hunter Albritton (ADDRESS) Sikeston Mo.

20. FILED 8-22 1939 Mrs. John Parrish Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8/13/39

22. I HEREBY CERTIFY, That I attended deceased from 8-13 to 8-13, 1939  
I last saw her alive on 8-13, 1939 Death is said to have occurred on the date stated above, at 7:30 pm  
The principal cause of death and related causes of importance were as follows:

Coronary Sclerotic Heart Disease - 8-29  
946  
Date of onset

Other contributory causes of importance:  
Hypertension - 8-29

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 1939  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? No  
If so, specify \_\_\_\_\_  
(Signed) W. H. Gardner M. D.  
(Address) Sikeston Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED

District Health Officer No. 2

District File Number 839-167

Date Filed 8-23

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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

- Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.