

Registration District No. **125**

Primary Registration District No. **3009**

Registrar's No. **80**

1. PLACE OF DEATH:

(a) County Cape Girardeau
 (b) City or town _____
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: St. Francis Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 8 days
 (Specify whether _____)
 In this community _____
 years, months or days 1 1/2

3. (a) PRINT FULL NAME George Washington Warren

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife Theodora Young 6. (c) Age of husband or wife if alive 77 years

7. Birth date of deceased Oct 4 1867
 (Month) (Day) (Year)

8. AGE: Years 72 Months 4 Days 21 If less than one day _____ hr. _____ min.

9. Birthplace Berryville Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation farmer

11. Industry or business _____

MOTHER FATHER { 12. Name Not known G

13. Birthplace _____ (City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Not known G

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Russell Warren

(b) Address 2711a Allen and St. Louis

17. (a) _____ (b) Date thereof 2-27-40
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cross Town Cemetery

18. (a) Signature of funeral director McComb Free Co.

(b) Address Jackson Mo.

19. (a) 2-24-40 (b) Jim Thompson
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cape Girardeau
 (c) City or town Jackson Mo
 (If outside city or town limits, write "RURAL")
 (d) Street No. Route #1
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 25
 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from 2-16, 1940, to 2-25, 1940
 that I last saw him alive on 2-25, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Diagnosis - Pneumonia
Diagnosis - Pneumonia

Due to 00RY39

Due to _____

Other conditions 93c
 (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (a) Means of injury _____

23. Signature A. J. Jewell (M. D. or other) MD

Address Cape Girardeau Date signed 2/25/40

WHILE FILLING IN THESE UNFADING BLACK INK - MAKE A PERMANENT RECORD

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.

1 X 10511

28.00
4-18-1
28.10

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 B. W. Meyer
Licensed Embalmer No. 3057
P. O. Address Jackson 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 this body is not embalmed, above space should be left blank.

28
-40
X2233

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH STANDARD CERTIFICATE OF DEATH

State File No. **6178**

Registration District No. **128**

Primary Registration District No. **3009**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Cape Girardeau
 (b) City or town Cape Girardeau
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether)
 In this community _____
years, months or days

3. (a) **PRIME** George Washington Warren
FULL _____

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife THEODOSIA 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>72</u>	<u>4</u>	<u>21</u>	_____ hr. _____ min.

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 4-2-40 (b) J. M. Thompson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
 (c) City or town _____
(If outside city or town limits write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Feb day 25
 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____
(Specify type of place) (e) Means of injury _____
 23. Signature H. L. French (M. D. or other) _____
 Address Cape Girardeau Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

