

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

16308
Do not use this space.

PLACE OF DEATH (104)
 (a) County Stone Registration District No. 843
 (b) Township Washington Primary Registration District No. 4513 Registered No. _____
 (c) City Galena, Mo. (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 H. J. Warren Sr.
 (a) Residence, No. Galena Mo. 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 m 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 6, 1876

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
63 7 3

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Lumberman
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation 29

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Osceola Mo.

FATHER 13. NAME William W. Warren

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Warrens Mo.

MOTHER 15. MAIDEN NAME Mary J. Coontz

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Clair Co. Mo.

17. INFORMANT (ADDRESS) Emma Warren Galena, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Osceola DATE April 11, 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Everett J. Cheatham Galena, Mo.

20. FILED Apr 11, 1940 Nellie Bromley Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 9, 1940

22. I HEREBY CERTIFY, That I attended deceased from April 9, 1940, to April 9, 1940. I last saw him alive on April 9, 1940. Death is said to have occurred on the date stated above, at 10:30 a.m.

The principal cause of death and related causes of importance were as follows:

apoplexy

Date of onset

Other contributory causes of importance:

atherosclerosis

Name of operation none Date of _____
 What test confirmed diagnosis? none 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 _____, 19____
 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) J. J. Gannon, M. D.

(Address) Galena 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. 6,

District File Number 540-1217

Date Filed MAY 6 1940

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

Everett J. Cheatham

Licensed Embalmer No. 3870

P. O. Address Malena, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 16308

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 843

Primary Registration District No. 4573

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Moore

(b) City or town Salina
(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)

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.

3. (a) PRINT FULL NAME Henry Jacob Warren Sr

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 9
year 1940 hour _____ minute _____ M.

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

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.

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

Immediate cause of death _____

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

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

8. AGE: Years 63 Months 7 Days 3 If less than one day _____ hr. _____ min.

Due to _____

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

Due to _____

10. Usual occupation _____

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

11. Industry or business _____

Major findings: Of operations _____

12. Name _____

Of autopsy _____

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. (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 4/11, 1940 (b) Nellie Ironley
(Date received local registrar) (Registrar's signature)

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 J. H. Jones (M. D. or other)

Address Salina Mo 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

ROWENA

