No. 2
11-10-39
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X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 28448

Registration District No. 294 Primary Registration District No. 4178 Registrar's No.

1. PLACE OF DEATH:

(a) County Franklin
(b) City or town St Clair (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community 15

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin
(c) City or town Saint Clair (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 JOSEPH R. WARREN
3. (b) If veteran, name war.
3. (c) Social Security No.

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Laura
6. (c) Age of husband or wife if alive years
7. Birth date of deceased June 11, 1864 (Month) (Day) (Year)

8. AGE: Years 76 Months 1 Days 28 If less than one day hr. min.

9. Birthplace Independence (City, town, or county) Iowa (State or foreign country)
10. Usual occupation Retired
11. Industry or business

FATHER
12. Name Ira Warren
13. Birthplace (City, town, or county) Vermont (State or foreign country)

MOTHER
14. Maiden name Adelia Jane Ward
15. Birthplace (City, town, or county) New York (State or foreign country)

16. (a) Informant Owen Warren
(b) Address St. Louis, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 12, 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Valhalla-St. Louis, Mo.
18. (a) Signature of funeral director Casey-Lenz
(b) Address St. Clair, Mo.
19. (a) (Date received local registrar) (b) W. A. Duckworth (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 9
year 1940 hour 10 minute 30 P.M.
21. I hereby certify that I attended the deceased from , 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Myocarditis	
Due to:	
Due to:	
Other conditions. (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy none	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Nat.
(b) Date of occurrence Aug. 9 1940
(c) Where did injury occur? St Clair (City or town) Franklin (County) Mo (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 267 At home (Specify type of place)
While at work? no (e) Means of injury

23. Signature Thos. P. Shoffner (M. D. or Coroner)
Address Sullivan Mo Date signed

(Licensed Embalmer's Statement on Reverse Side)

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. Lenox

Licensed Embalmer No. 3601

P. O. Address St. Louis, Mo.

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

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