

FILED SEP 24 1940

Registration District No. **345** Primary Registration District No. **45-53**

Registrar's No.

## 1. PLACE OF DEATH:

(a) County NEW MADRID  
 (b) City or town MATTHEWS  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
No  
 (If not in hospital or institution, write street number and location)  
 (d) Length of stay: In hospital or institution No  
 (Specify whether  
 In this community 5 YEARS ABOVNT.  
 years, months or days)

8. (a) PRINT  
FULL NAMEJOHN WREN (SD)8. (b) If veteran,  
name war No3. (c) Social Security  
No. No

4. Sex N 5. Color or  
race W. 6. (a) Single, widowed, married,  
divorced WIDOWED.  
6. (b) Name of husband or wife ALICE WREN 6. (c) Age of husband or wife if  
alive No years  
7. Birth date of deceased ABOUT.  
(Month) (Day) (Year) 1861

8. AGE: Years Months Days If less than one day  
ABOUT 79 hr. min.

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

10. Usual occupation NONE11. Industry or business NO12. Name UNK. 913. Birthplace UNK.  
(City, town, or county) (State or foreign country)14. Maiden name UNK. 915. Birthplace UNK.  
(City, town, or county) (State or foreign country)16. (a) Informant SOCIAL SECURITY OFFICE(b) Address NEW MADRID, MO17. (a) BURIAL (b) Date thereof 7-27-1940  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation EVERGREEN18. (a) Signature of funeral director NONE.(b) Address NO19. (a) (Date received local registrar) (b) (Registrar's signature) V

## 2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County NEW MADRID.  
 (c) City or town MATTHEWS  
 (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 7 day 27  
 year 1940 hour 4:00 minute P.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 No medical attention DurationParalysis UNK

Due to \_\_\_\_\_

Due to GGHOther conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

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? 892While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury Cosmer's23. Signature Fabeh... (M. D. or other) Cosmer'sAddress new madrid Date signed 8-20

RECEIVED

District Health Officer

District File Number 940-14

Date Filed 9/11/40

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**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 comply the above constitutes grounds for revocation of license.)**

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

Registration District No. **345-**

Primary Registration District No. **4523**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County **New Madrid**  
(b) City or town **Mathews**  
(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, month or days)

3. (a) PRINT FULL NAME

**John Wren**

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 **w**  
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 **abt 79** Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ 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 \_\_\_\_\_ (City, town, or county) (State or foreign country)

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) **Nov 5** (b) **Mildred Deane** (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 **7** day **27**  
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 **L.H. Richards Jr** (City, town, or county)  
Address **New Madrid** Date **Nov 5**

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

