

SEP 25 1940

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

29381
Do not use this space.

1. PLACE OF DEATH
 (a) County Pike Registration District No. 687
 (b) Township Prairieville Primary Registration District No. 687 Registered No. _____
 (c) City _____ (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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME David 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 Male 4. COLOR OR RACE Black 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 25th 1845

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
94 8 11

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. farmer
 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) Sept. 1st 1940 11. Total time (years) spent in this occupation 80 yr.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Eolia Pike Co. Mo.

FATHER 13. NAME Stevens Warren
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

MOTHER 15. MAIDEN NAME unknown
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

17. INFORMANT (ADDRESS) Chloe Warren
Eolia Mo.

18. BURIAL CREMATION, OR REMOVAL PLACE Mt. Air DATE Sept 28 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Gooch & Adair Co.,
Eolia Mo.

20. FILED Sept 7th 1940 V. M. Gooch
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) September 5, 1940

22. I HEREBY CERTIFY, That I attended deceased from April 22, 1939, to September 5, 1940
 I last saw him alive on Sept. 5th, 1940 Death is said to have occurred on the date stated above, at 5:30 Pm.
 The principal cause of death and related causes of importance were as follows:
Chronic interstitial nephritis Date of onset ?
 Other contributory causes of importance: 181
Cerebral Hemorrhage 9-1 1940
 Name of operation None Date of _____
 What test confirmed diagnosis: Urinalysis 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) Dr. D. G. Hazard M. D.
 (Address) Eolia, Missouri

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.

SEP 16 1941

RECEIVED

District Health Officer No. 10

District File Number ⁹⁻⁴⁰⁻¹⁷⁸⁰

Date Filed SEP 18 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 Norman E. Gooch

Licensed Embalmer No. 2342

P. O. Address Edlia, 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.

Registration District No. **687**

Primary Registration District No. **3915-**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Pike**
(b) City or town **Princeton**
(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) PRINT FULL NAME **David Warren**

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

4. Sex **m** 5. Color **Black** 6. (a) Single, widowed, married, divorced **m**
6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

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

8. AGE: Years **94** Months **8** Days **11** 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 _____

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) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **Pike**
(c) City or town **Rural**
(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 **Sept** day **5-**
year **1940** 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 _____

Duration

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) _____

(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 **D. G. Hazard** (M. D. or other) _____

Address **Colin Blue** Date signed _____

SUPPLEMENTAL

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

