

Registration District No. 471

Primary Registration District No. 2002

Registrar's No. _____

EMER NOV 15 1940

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Anderson
(c) Name of hospital or institution: Freeman Hospital
(d) Length of stay: In hospital or institution 2 days
In this community 55 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County McDonald
(c) City or town Anderson, Mo
(d) Street No. R.R. 2
(e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT FULL NAME Joseph Franklin 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 _____

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

7. Birth date of deceased Feb 9 - 1959
(Month) (Day) (Year)

8. AGE: Years 81 Months 7 Days 0 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farming

11. Industry or business _____

12. Name Joseph Warren

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

14. Maiden name Henry

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

16. (a) Informant H. C. Warren

(b) Address Hoff City Mo

17. (a) burial (b) Date thereof 10-10-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Anderson

18. (a) Signature of funeral director Jasper Funeral Home

(b) Address Box 75 to Emerson

19. (a) 10-12-40 (b) Ed J. Jarner
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 9
year 1940 hour 3 30 a.m. minute _____ M.

21. I hereby certify that I attended the deceased from 9/7/40
8/2/40 19____ to 9/9/40 19____
that I last saw him alive on 9/8/40 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Obstruction of Bowels
Duration 4-5 days

Due to Possible carcinoma of intestines

Due to _____

Other conditions 4/0
(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? 372 (Specify type of place)

(e) Means of injury _____

23. Signature J. Alkinworth (M. D. or Physician)
Address Jasper, Mo Date signed 10/14/40

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 with the above constitutes grounds for revocation of license.)

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