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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 18 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

22218
State File No.

District No. 566

Primary Registration District No. 5762

Registrar's No. 72

1. PLACE OF DEATH:

(a) County Mississippi

(b) City or town Charleston (Rural)
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Route # 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community 20 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mississippi

(c) City or town Charleston
(If outside city or town limits, write "RURAL")

(d) Street No. Route #1 (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Callie Warren

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female 5. Color or race Negro

6. (a) Single/widowed, married, divorced, Married

6. (b) Name of husband or wife Alfred Warren 6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased December 6, 1896
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

44 6 14 hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Richard Hubbard

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

14. Maiden name Julie (Unknown)

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

16. (a) Informant Engene Riggs (son)

(b) Address Charleston, Mo., Route 1

17. (a) Burial (b) Date thereof June 22, 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director F. J. Sparks

(b) Address Cape Girardeau, Mo.

19. (a) June 21st 41 (b) F. J. Vernon
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 20
year 41 hour 9 minute 20 AM.

21. I hereby certify that I attended the deceased from 6-14-1941 to 6-19-1941
that I last saw her alive on 6-19- and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Heart Disease
RT. Hemiplegia

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

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? _____

745 (Specify type of place) While at work? _____ (e) Means of injury _____

23. Signature W. A. Lingal (M. D. or other) _____
Address 204 S. Locust St. Charleston Date signed 6-21-41

932

RECEIVED

District Health Officer No. 2,

District File Number 741-904

Date Filed 7/16/41

FEB 13 1958

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 Frank Sparks
Licensed Embalmer No. 3455
P. O. Address Cape Girardeau

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 22218

Registration District No. 566

Primary Registration District No. 5762

Registrar's No. 72

1. PLACE OF DEATH:

(a) County Mississippi
(b) City or town Rural
(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 MO (b) County Mississippi
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Callie Warren

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

4. Sex J 5. Color or race B 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 _____ Months _____ Days _____ If less than one year _____ min

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____ (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) _____ (b) W. A. Singal (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 20 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that last saw h _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: Hypertensive heart disease
E. Pt. Hemiplegia

Due to Cerebral Hemorrhage

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 W. A. Singal (M. D. or other) _____
Address 204 S. Locust St. Charleston Mo Signed _____

SUPPLEMENTARY

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

Charleston Mo

MOTHER FATHER

