DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 6 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 27894

Registrar's District No. 69 Primary Registration District No. 3007 Registrar's No. 338

1. PLACE OF DEATH:
(a) County Butler
(b) City or town Poplar Bluff
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Lucas Lee Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Life (Specify whether years, months or days)
In this community Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Wayne
(c) City or town Williamsville
(If outside city or town limits, write "RURAL")
(d) Street No. 1
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Baby Warren
3. (b) If veteran, name war ____
3. (c) Social Security No. ____
4. Sex Male
5. Color or race W
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife ____
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased August (Month) 28 (Day) 1941 (Year)
8. AGE: Years ____ Months ____ Days ____ If less than one day 6 hr. ____ min.
9. Birthplace Poplar Bluff (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Infant
11. Industry or business ____
FATHER
12. Name Walter B. Warren
13. Birthplace Leeper (City, town, or county) Missouri (State or foreign country)
MOTHER
14. Maiden name Bertha Ann Brown
15. Birthplace Henrickson (City, town, or county) Missouri (State or foreign country)
16. (a) Informant's own signature W. B. Warren
(b) Address Williamsville, Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-28-41 (Month) (Day) (Year)
(c) Place: burial or cremation Williamsville, Mo.
18. (a) Signature of funeral director Greer Croy Service
(b) Address Poplar Bluff, Missouri
19. (a) 9-2-41 (Date received local registrar) (b) Belle Kinne (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 28 year 1941 hour 6 minute 30 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.

	Duration
Immediate cause of death: Premature	
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? ____
While at work? ____ (Specify type of place) (e) Means of injury ____

23. Signature J. W. McPherson (M. D. or other)
Address ____ Date signed ____

(Licensed Embalmer's Statement on Reverse Side)

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

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.

I X10511

RECEIVED
District Health Office No. 2,
District File Number 941-1225
Date Filed 9/4/42

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.

Not Embalmed

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.

6. No. 2B
1—8-21-41
P I X29288

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. 27894

Registration District No. 89 Primary Registration District No. 3007 Registrar's No. 338

1. PLACE OF DEATH:
(a) County Butler
(b) City or town Poplar Bluff
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Ivy Lee Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Life (Specify whether years, months or days)
In this community Life

2. USUAL RESIDENCE OF DECEASED: Butler
(a) State Mo. (b) County ~~Wayne~~
(c) City or town Poplar Bluff
(If outside city or town limits, write "RURAL")
(d) Street No. Poplar Bluff Hospital
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Baby Warren
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 S
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 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
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 10-3-41 (Date received local registrar) (b) Belle Kinne (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. Day 28 year 1941 hour minute 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	
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)
(b) 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 (M. D. or other)
Address Date signed

SUPPLEMENTARY