

3. No. 2
M-5-43
5-17-39
I X38671

FILED OCT 24 1945 **STANDARD CERTIFICATE OF DEATH**

State File No. **33268**
Registrar's No. **1093**

Registration District No. **42**

Primary Registration District No. **1000**

1. PLACE OF DEATH

(a) County Buchanan
(b) City or town St Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution St Joseph Hospital - 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 hrs
(Specify whether years, months or days) Unknown Est.

3. (a) PRINT FULL NAME LEONARD GUFFY WARREN

3. (b) If veteran, name was no information
3. (c) Social Security No. no information

4. Sex M 0 5. Color of race W
6. (a) Single, widowed, married, divorced no information

6. (b) Name of husband or wife
6. (c) Age of husband or wife if

This man was unidentified
7. Birth date of deceased Could get no information

8. AGE ESTIMATED AGE 30 yrs
Years Months Days Less than one day

9. Place of birth from
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant

(b) Address

17. (a) Burial
(Burial, cremation, or removal) (b) Date thereof 10-10-45
(Month) (Day) (Year)

(c) Place: burial or cremation St Joseph Cem

18. (a) Signature of funeral director Kallus-Rueh

(b) Address Edgerton, Mo

19. (a) 10/12/45
(Date received local registrar) (b) [Signature]
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Cook 999
(c) City or town Chicago 11
(If outside city or town limits, write "RURAL")
(d) Street No. 949 Madison
(If rural, give location)
(e) Citizen of foreign country? No
(Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCTOBER day 10th
year 1945 hour 9 minute 30 15 PM

21. I hereby certify that I VIEWED the deceased on Oct. 4, 1945
that I last saw h. alive on
and that death occurred on the date and hour stated above.

Immediate cause of death fracture of skull

Due to Automobile accident - collision of two automobile

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) Accident

(b) Date of occurrence Oct, 4, 1945

(c) Where did injury occur? Clinton, Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Highway 169

While at work? No (Specify type of place) (e) Means of injury Auto collision

23. Signature [Signature]
Address Coroner, Cameron, Mo Date signed 10/8/45

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

MOTHER FATHER

1428

ESTIMATED AGE 20

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 Wm R. Nash

Licensed Embalmer No. 3947

P. O. Address Edgerton 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, fact should be so stated above.