

**FILED MAR 1 1947**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH**

(a) County St. Clair

(b) City or town \_\_\_\_\_  
(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  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County St. Clair

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

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** David Bailey Warren

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Eva Warren 6. (c) Age of husband or wife if alive 77 years

7. Birth date of deceased April 4 1865  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>81</u>	<u>6</u>	<u>21</u>	hr. _____ min. _____

9. Birthplace Callaway Co. Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Minister

11. Industry or business \_\_\_\_\_

**MOTHER FATHER**

12. Name W. W. Warren

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

14. Maiden name Mary Ellen Cannon

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) Burial (b) Date thereof Oct. 27, 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Osceola Cemetery

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

(b) Address Osceola, Missouri

19. (a) 11-1-46 (b) Ruth Seivors  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month October day 25  
year 1946 hour 2 minute 25 A.M.

21. I hereby certify that I attended the deceased from July  
1946 to Oct 25, 1946,  
that I last saw him alive on Oct 10, 1946,  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis

Due to neural insufficiency

Due to \_\_\_\_\_

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

**PHYSICIAN**

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

12-13

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) (c) Means of injury 0

23. Signature Ruth Seivors (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed 10-25-46

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

LT 34-C

6-5-67-1

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**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: *J.B. Goodrich*

Licensed Embalmer No. *3038*

P. O. Address: *Quincy 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.