

No. 2
11-10-39
1-17-39
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

7662

FILED MAR 7 1947

State File No. _____

Registration District No. 369

Primary Registration District No. 6225

Registrar's No. 37

1. PLACE OF DEATH:

(a) County Vernon

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

(c) Name of hospital or institution: State Hospital # 32
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

In this community Ops - 6 Mos - 29 days

8. (a) PRINT FULL NAME David T. Warren

8. (b) If veteran, name war ?

8. (c) Social Security No. ?

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife ✓

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 7-4-1878
(Month) (Day) (Year)

8. AGE: Years 69 Months 7 Days 22
If less than one day hr. min.

9. Birthplace East River N.Y.
(City, town, or county) (State or foreign country)

10. Usual occupation Labourer

11. Industry or business _____

MOTHER FATHER

12. Name David Warren

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

14. Maiden name Mary Temperance

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

16. (a) Informant Records

(b) Address State Hospital

17. (a) Buried (b) Date thereof 2-27-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hospital Cemetery

18. (a) Signature of funeral director Henry J. ...

(b) Address Meroda Mo

19. (a) 2-28-47 (b) Lillian ...
(Date received local registrar's) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Webster¹⁰⁸

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

(d) Street No. Rural
(If rural, give location)

(e) If foreign born, how long in U. S. A. ✓ _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 26
year 1947 hour 5:55 minute A M.

21. I hereby certify that I attended the deceased from 7-27-47 to 2-26-47
that I last saw him alive on 2-25-47
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia
Pleural
Generalized Arteriosclerosis D.T.

Duration 2 days

Due to _____

Due to _____

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

PHYSICIAN

Major findings: Pneumonia

Of operations Yes, Autopsy

Of autopsy _____

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 _____

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 Dr. ... (M. D. or other) _____

Address State Hospital # 3 Date signed 2-26-47

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

581

RECEIVED
District Health Officer No. 7,
District File Number 2-47-186
Date Filed 3-5-47

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 L B Ferry

Licensed Embalmer No. 1760

P. O. Address Meroda 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, above space should be left blank.