S. No. 2
I—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED OCT 29 1947

Registration District No. 217

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5786

State File No. 35095

Registrar's No. 98

1. PLACE OF DEATH:
(a) County: Mississippi
(b) City or town: Wyatt, Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 6 mi S. E. of Wyatt
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: /
In this community: 10 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Mississippi
(c) City or town: Wyatt, Rural
(If outside city or town limits, write "RURAL")
(d) Street No.: 6 mi S. E. of Wyatt
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: Earley Warren
3. (b) If veteran, name war: No.
3. (c) Social Security No.: None
4. Sex: Male
5. Color or race: Negro
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Annie Warren
6. (c) Age of husband or wife if alive: 54 years
7. Birth date of deceased: July (Month) 29, (Day) 1881 (Year)

8. AGE:

Years	Months	Days	If less than one day
66	2	5	hr. min.

9. Birthplace: Westpoint, (City, town, or county) Mississippi (State or foreign country)
10. Usual occupation: Farmer
11. Industry or business: None
FATHER
12. Name: No Record
13. Birthplace: No Record (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name: Maggie (No record)
15. Birthplace: Westpoint, Mississippi (City, town, or county) (State or foreign country)
16. (a) Informant: Annie Warren
(b) Address: R#3, Charleston, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10-7-1947 (Month) (Day) (Year)
(c) Place: burial or cremation: Oak Grove Cemetery Charleston, Missouri
18. (a) Signature of funeral director: Joe R. Runnels
(b) Address: Charleston, Missouri.
19. (a) 10-21-47 (Date received local registrar) (b) Mrs. John Bondurant (Registrar's signature) 141

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 4th year 1947 hour 3:00 minute 45 P.M.

21. I hereby certify that I attended the deceased from Sept. 4, 1947, to Oct 4, 1947, that I last saw him alive on Sept 26, 1947, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral hemorrhage	2 mon
Due to: undetermined	
Cause	
Due to:	
Other conditions: (Include pregnancy within 3 months of death)	
Major findings: Of operations: —	
Of autopsy: —	

PHYSICIAN

Underline the cause of 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? (Specify type of place)
While at work? (e) Means of injury: —

23. Signature: Wilbur Weir (M. D. or other) MD
Address: Charleston Mo. Date signed: 10-10-47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 1047-1383
Date Filed 10-27-

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 Joe R. Nunnelee

Licensed Embalmer No. 4413

P. O. Address Charleston, 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.