

No. 2
-5-43
5-17-39
X36671

Dr. Hyde

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18416

FILED JUN 14 1948

Registration District No. 334

Primary Registration District No. 6128

Registrar's No.

1. PLACE OF DEATH:

(a) County Shannon
(b) City or town Eminence
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: None
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 34 years (Specify whether years, months or days)
In this community 34 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Shannon
(c) City or town Eminence
(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 Raymond Lee Warren

3. (b) If veteran, name war no 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife none 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct 14 1913
(Month) (Day) (Year)

8. AGE: Years 34 Months 7 Days 3 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farming

11. Industry or business _____

MOTHER FATHER

12. Name John William Warren
13. Birthplace Eminence Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Florence Sherrell
15. Birthplace Shannon Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Florence Warren
(b) Address Eminence, Mo.

17. (a) Burial (b) Date thereof 5-20-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Grassy Hollow Cem.

18. (a) Signature of funeral director Duncan Funeral Home
(b) Address Mountain View, Mo.

19. (a) 6-7-48 (b) Frank Hyde
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 17
year 1948 hour 6 minute 40 a.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.

Immediate cause of death Cerebral Tuberculosis

Due to _____
Due to _____

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

Major findings: Of operations _____
Of autopsy _____

Duration

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 Frank Hyde (M.D. or other) _____
Address Eminence Date signed 5-20-48

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

RECEIVED 6-9-48
District Health Officer No. 5,
District No. 648386
Date Recd. 6-11-48

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. Duncan
Licensed Embalmer No. 4325
P. O. Address Mt. View, 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.