

FILED APR 13 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 13037  
67

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 155 PRIMARY REG. DIST. NO. 4244 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>Jasper</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Jasper</b>	
b. CITY (If outside corporate limits, write RURAL and give town) <b>Carterville</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Carterville</b> 0490	
c. LENGTH OF STAY (in this place) <b>47 Years</b>		d. STREET ADDRESS (If rural, give location) <b>302 West Hall St.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>302 West Hall St.</b>			

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Nancy</b>	b. (Middle) <b>Leoria</b>	c. (Last) <b>Warren</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>April 11, 1951</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Dec. 23, 1876</b>	9. AGE (In years last birthday) <b>74</b>	IF UNDER 1 YEAR Months <b>3</b> Days <b>18</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>Texas County, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Thomas Cassidy</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Sherman Warren (Deceased)</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Elsie Warren, Carterville, Missouri</b>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Hypostatic lobar pneumonia</b>		<b>2 days</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Infectious myocarditis</b> DUE TO (c) <b>Chronic cholecystitis</b>		<b>2 weeks</b> <b>Unknown</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Generalized arteriosclerosis</b>		<b>Unknown</b>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **3/19**, 19 **49**, to **4/11/51**, 19 **51**, that I last saw the deceased alive on **4/11**, 19 **51**, and that death occurred at **11:00 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Type or Print) <b>Mrs. Webb-Dee &amp; Co.</b>	23b. ADDRESS <b>924 W. Daugherty, Webb City, Mo.</b>	23c. DATE SIGNED <b>4/13/51</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>April 14, 51</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Carterville Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Carterville, Missouri</b>
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DATE REC'D BY LOCAL REG. <b>Apr 14-51</b>	REGISTRAR'S SIGNATURE <b>[Signature]</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Johnston-Arnice-Simpson, Webb City, Mo.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

490  
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RECEIVED 4-17-51

Deer County Health Office

County File Number 51-4-330

Filed 4-17-51

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 myself

working under my personal supervision.

Student Embalmer No. ....

Signed.....  
Student Embalmer

Signed Clayton M. Johnston

Licensed Embalmer No. 4304

P. O. Address Well City, 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.