

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED DEC 6 1955

State File No. **36415**

BIRTH NO. _____ REG. DIST. NO. **101** PRIMARY REG. DIST. NO. **4173** Registrar's No. **57**

1. PLACE OF DEATH a. COUNTY Dangloss		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Dangloss	
b. CITY (If outside corporate limits, write RURAL and give township) Ava		c. CITY OR TOWN Squires	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION		e. STREET ADDRESS (If rural, give location) 0340	

3. NAME OF DECEASED (Type or Print)	a. (First) Robert E. Lee	b. (Middle)	c. (Last) Warden	4. DATE OF DEATH (Month) (Day) (Year) Nov. 27, 1955
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5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH Jan. 14, 1915	9. AGE (In years last birthday) 83	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HR. Hours	IF UNDER 1 HR. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith	10b. KIND OF BUSINESS OR INDUSTRY Ruin Shop	11. BIRTHPLACE (City and State or Foreign Country) Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME John Warden	13b. MOTHER'S MAIDEN NAME Susan	14. NAME OF HUSBAND OR WIFE
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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) no.	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Mark L. Warden - Wasala, Mo.	ADDRESS
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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, asthemia, 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) Chronic Diabetes Mellitus		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 260X.		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Acute Gangrene of Left Foot			

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) m.	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 **11-26-55**, to **11-29-55**, that I last saw the deceased alive on **11-27-55**, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) M.C. Gentry M.D.	23b. ADDRESS Ava Mo	23c. DATE SIGNED 11-28-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11-29-55	24c. NAME OF CEMETERY OR CREMATORY Murray	24d. LOCATION (City, town, or county) (State) Squires MO.
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DATE REC'D BY LOCAL REG. 12-2-55	REGISTRAR'S SIGNATURE Uestel Bushman 84	25. FUNERAL DIRECTOR'S SIGNATURE Chickling Beard	ADDRESS Funeral Home Ava, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Charles R. Fish*.....

Licensed Embalmer No. *466*.....

P. O. Address *Avon, Mass.*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.