

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-013409

STATE FILE NUMBER

FILED APR 24 1958

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 328

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Butler</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Wayne</u> <u>1110</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Poplar Bluff</u>		c. CITY OR TOWN <u>Williamsville</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Poplar Bluff H.</u>		d. STREET ADDRESS (If outside, give location) <u>None</u>	
3. NAME OF DECEASED (Type or print) First <u>Don</u> Middle <u>Lavoy</u> Last <u>Warren</u>		4. DATE OF DEATH Month <u>April</u> Day <u>6</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>April 16 1930</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Williamville, Mo. 0</u>
13a. FATHER'S NAME <u>Raymond A Warren</u>		13b. MOTHER'S MAIDEN NAME <u>May Goforth</u>	14. NAME OF HUSBAND OR WIFE <u>Marjorie Waller</u> <u>(deceased)</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes Korean</u>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>Raymond A. Warren Williamville</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Basilar Skull fracture</u>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Auto accident</u>	
20c. TIME OF INJURY . Hour Month, Day, Year a.m. <u>4-6-58</u> p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Highway</u>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>Williamsville Wayne Mo.</u>	
21. I attended the deceased from <u>4-6-58</u> to <u>4-6-58</u> and last saw him alive on <u>4-6-58</u> Death occurred at <u>5:15 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>William</u>		22b. ADDRESS <u>Poplar Bluff, Mo</u>	22c. DATE SIGNED <u>4-10-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4/8/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holladay Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Williamsville, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>William Goder Richmond</u>		25. DATE RECD. BY LOCAL REG. <u>4/19/58</u>	26. REGISTRAR'S SIGNATURE <u>Esther Metree</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

RECEIVED
BUTLER CO. HEALTH CENTER
APR 21 1958
FILE No. _____

JUN 17 1958

APR 24 1958

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 Cader Funeral Home, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed William Cochran

Licensed Embalmer No. 3723
P. O. Address Piedmont

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.