Health, Welfare Public Service

300 -57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-031429

STATE FILE NUMBER

FILED AUG 25 1958 Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 128

1. PLACE OF DEATH
a. COUNTY Saline
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Marshall — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 633 East Arrow — Length of stay in lb 30 years

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Saline
c. CITY OR TOWN Marshall 0972 — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 633 East Arrow — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First Middle Last: Grace Anne Duffie Warren

4. DATE OF DEATH Month Day Year: August 17th 1958

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Oct. 9th 1890
9. AGE (In years last birthday): 67 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Receptionist
10b. KIND OF BUSINESS OR INDUSTRY: Doctors office
11. BIRTHPLACE (City and state or country): Kirksville Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: Abe G. Duffie
13b. MOTHER'S MAIDEN NAME: Ella Hayward
14. NAME OF HUSBAND OR WIFE: Dr. C.F.Warren

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ---------
16. SOCIAL SECURITY NO.: None
17. INFORMANT Address: Dr.C.F.Warren, Marshall Missouri

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Adeno-Canthoma of Uterus — INTERVAL BETWEEN ONSET AND DEATH 18 mo
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c) 174X
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 [ ] NO [X] 9

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Aug 1 58, to Aug 17 58 and last saw her alive on Aug 9 1958
Death occurred at 10-50 A. M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Richard N Muckles Do.
22b. ADDRESS: Marshall Mo
22c. DATE SIGNED: 8-18-58

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Aug.19,1958
23c. NAME OF CEMETERY OR CREMATORY: Ridge Park cemetery
23d. LOCATION (City, town, or county) (State): Marshall Missouri

24. FUNERAL DIRECTOR ADDRESS: Campbell-Lewis, Marshall Mo.
25. DATE RECD. BY LOCAL REG.: 8-18-58
26. REGISTRAR'S SIGNATURE: Cecil G. Read

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

AUG 28

MAR 29 1962

JAN 19 1961

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 James H. Lewis Jr.

Licensed Embalmer No. 4709

P. O. Address Marshall, M

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.