

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026344

FILED VS JUL 21 1959

Registration District No. 216 Primary Registration District No. \_\_\_\_\_ Registrar's No. 275 STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <u>Missouri</u> <u>St. Francois</u>			
b. CITY (If outside corporate limits give location) <u>St. Francois Twp.</u> Length of stay in 1b OR TOWN <u>Farmington -rural</u>			3 Yrs.		c. CITY OR TOWN <u>Flat River</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) <u>Thomas Dell Nursing Home</u>				Inside Limits No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>401 Third St.</u>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>THOMAS</u> Last <u>WARREN</u>				4. DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>1959</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10/14/1884</u>	9. AGE (last birthday) <u>74</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>28</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Van Buren, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>William Warren</u>			13b. MOTHER'S MAIDEN NAME <u>Nancy Stratton</u>			14. NAME OF HUSBAND OR WIFE <u>Ilah Caroline Warren</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Address <u>Mrs. I. C. Warren Flat River, Mo</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>Congestive circulatory failure</u> DUPLICATE (b) <u>Inanition and debilitation and prolonged recumbency</u> DUPLICATE (c) <u>Arthritis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>14 hr</u> <u>yrs</u> <u>yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)					
20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u> Month, Day, Year <u></u>							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <u>7-11-59</u> to <u>7-12-59</u> and last saw <sup>her</sup> him alive on <u>7-11-59</u> Death occurred at <u>2:48 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Regree or title) <u>R. A. Neidigat D. O.</u>				22b. ADDRESS <u>Farmington, Mo.</u>			22c. DATE SIGNED <u>7-15-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>7/14/1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Francois Memorial</u>		23d. LOCATION (City, town, or county) (State) <u>St. Francois Co. Mo.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Murphy L. Sparks Flat River, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>July 16, 1959</u>		26. REGISTRAR'S SIGNATURE <u>Eather Rudloff</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Murphy L Sparks  
Licensed Embalmer No. 4236  
P. O. Address Slatter

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.