

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **36551**

Registration District No. **496**

Primary Registration District No. **3025**

Registrar's No. **98**

1. PLACE OF DEATH:
(a) County **Linn**
(b) City or town **Brookfield**
(c) Name of hospital or institution:
125 East Clayton Street
(d) Length of stay: In hospital or institution **3 1/2** years
In this community **3 1/2** years

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Linn**
(c) City or town **Brookfield**
(d) Street No. **135 East Clayton**
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME **Walter Warren**
3. (b) If veteran, name war _____
3. (c) Social Security No. **486-12-7137**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **October** day **3**
year **1939** hour **7** minute **15** A. M.

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Maudie Richardson Warren**
6. (c) Age of husband or wife if alive **36** years
7. Birth date of deceased **Sept. 22, 1878**

21. I hereby certify that I attended the deceased from **Sept 3**, 1939, to **Oct 3**, 1939, that I last saw him alive on **Oct 3**, 1939, and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	61		11	hr. _____ min. _____

Immediate cause of death
Coronary Embolism
Pt. Myocardium
Due to **Coronary Atherosclerosis**
Pt. sided Heart Failure

9. Birthplace **Sullivan County, Missouri**
10. Usual occupation **Farmer-Mechanic**
11. Industry or business **Farming and day labor**

Other conditions (Include pregnancy within 3 months of death)
Due to _____
Due to _____

MOTHER FATHER
12. Name **James Jackson Warren**
13. Birthplace **Not known**
14. Maiden name **Melissa Clem**
15. Birthplace **Not Known**

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically

16. (a) Informant's own signature **Maudie Warren**
(b) Address **Brookfield, Mo.**
17. (a) **Burial** (b) Date thereof **10-3-39**
(c) Place: burial or cremation **Garner Cemetery**
18. (a) Signature of funeral director **Russ Funeral Home**
(b) Address **Brookfield, Mo.**
19. (a) **Oct 3 - 39** (b) **Walter Warren**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature **Adam Evans** (M. D. or other) _____
Address **Brookfield Mo** Date signed **10-3-39**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REV. 5-17-39
1 X 9351

RECEIVED

District Health

Office

St. Louis

NOV 6

1939

1129-1441

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed..... *H. B. Wright*

Licensed Embalmer No. *3718*

P. O. Address. *Brookfield, 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, above space should be left blank.