

Registration District No. **318** Primary Registration District No. **5440**

1. PLACE OF DEATH:

(a) County **GREENE**
(b) City or town **Springfield**
(c) Name of hospital or institution: **Frank Osteopathic Hospital**
(d) Length of stay: In hospital or institution **one week 3**
In this community **3** years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Webster Co.**
(c) City or town **Rural (Marshfield)**
(d) Street No. **121**
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME **Mary Annette Warren**

3. (b) If veteran, name war **X** 3. (c) Social Security No. **X**

4. Sex **Female** 5. Color or race **white**
6. (a) Single, widowed, married, divorced, **widowed**
6. (b) Name of husband or wife **David Warren** 6. (c) Age of husband or wife if alive **58**
7. Birth date of deceased **May 3 - 1858**

8. AGE: Years **81** Months **9** Days **14** If less than one day **8 hr. 20 min.**

9. Birthplace **Delaware Co.** **Rural**
(City, town, or county) (State or foreign country)

10. Usual occupation **housewife**

11. Industry or business _____

MOTHER FATHER { 12. Name **John Price**
13. Birthplace **Unknown** **Virginia**
14. Maiden name **Margaret Burdick**
15. Birthplace **Unknown** **Canada**

16. (a) Informant **Mable Bell**
(b) Address **Carrollton Mo**

17. (a) **burial** (b) Date thereof **2-19-40**
(c) Place: burial or cremation **Ebenezer Church**

18. (a) Signature of funeral director **Chas. A. George**
(b) Address **Marshfield, Mo 65009**

19. (a) **2/19/40** (b) **Chas. A. George**
(Date received by registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **17th**
year **1940** hour **8:20** minute **7** P. M.
21. I hereby certify that I attended the deceased from **2/10/40**
to **2/17** 19 **40**
that I last saw her alive on **2-17** 19 **40**
and that death occurred on the date and hour stated above.

Immediate cause of death **Renal-cardiac-vascular**
Chronic
Due to **121**
Other conditions (Include pregnancy within 3 months of death) _____

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

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? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work _____ (Specify type of place) _____ (Means of injury)
23. Signature **William D. Stase** (M-D. or other) **20**
Address **Springfield, Mo** Date signed **2/17/40**

WRITE PLAINLY—USE 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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.

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