

No. 2  
11-10-39  
5-17-39  
I X21

FILED MAY 13 1940

Registration District No. 305

Primary Registration District No. 5422

Registrar's No. 10

1. PLACE OF DEATH:

(a) County Gasconade Co.  
(b) City or town Canaan  
(c) Name of hospital or institution: None  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2  
In this community 2  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Gasconade  
(c) City or town Rural  
(d) Street No. 0  
Canaan (If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME JAMES H. WARREN

8. (b) If veteran, name war \_\_\_\_\_ No. \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

4. Sex male 5. Color or race White 6. (a) Single, widowed, married, divorced widowed  
6. (b) Name of husband or wife Amanda Matthews 6. (c) Age of husband or wife if alive Deceased years  
7. Birth date of deceased Oct. 19 - 1854  
(Month) (Day) (Year)

8. AGE: Years 85 Months 5 Days 29 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace North Fea Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name Robert Warren

13. Birthplace North Carolina  
(City, town, or county) (State or foreign country)

14. Maiden name Armenta Shelton

15. Birthplace Not known  
(City, town, or county) (State or foreign country)

16. (a) Informant Wanzo Matthews

(b) Address Fea Mo

17. (a) Burial (b) Date thereof 4-20 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Warren Cemetery Fea Mo

18. (a) Signature of funeral director W.F. Gathenreiter  
(b) Address Donnellville Mo

19. (a) 4-28-40 (b) D. Wick A. Bunn  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April, day 18  
year 1940 hour 07 minute 30 A. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Heart trouble and  
Senility. Coronary  
Due to Investigation,  
Due to no physician  
Other conditions 16  
(Include pregnancy within months of death)  
Major findings treated him,  
Of operations none  
Of autopsy none  
PHYSICIAN \_\_\_\_\_  
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) no

(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?  
958 (Specify type of place) (e) Means of injury Coronary

23. Signatures P. A. Bunge (M. D. or other) \_\_\_\_\_  
Address Bland Mo Date signed 4-18 1940

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

loyd Gicks, Registered Apprentice No. 247  
working under my personal supervision.

Signed W.F. Gattusistrater

Licensed Embalmer No. 1444

P. O. Address Owensville 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.**