

ED AUG 26 1943

Registration District No. 333

Primary Registration District No. 3074

Registrar's No. \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Sikeston.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Dr. M. C. Mills Clinic  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution X  
(Specify whether years, months or days)

In this community X  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid

(c) City or town Rural  
(If outside city or town limits, write "RURAL")

(d) Street No. 5 Miles So. West Of Matthews  
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Harley Dean Warren

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced X

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased 3 14 1935  
(Month) (Day) (Year)

| 8. AGE: | Years    | Months   | Days      | If less than one day |
|---------|----------|----------|-----------|----------------------|
|         | <u>8</u> | <u>4</u> | <u>19</u> | hr. _____ min.       |

9. Birthplace New Madrid Co. Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER { 12. Name G. W. Warren

{ 13. Birthplace Mt. Levi Ark.  
(City, town, or county) (State or foreign country)

{ 14. Maiden name Rodh C. Lund

{ 15. Birthplace Hageraville, Ark.  
(City, town, or county) (State or foreign country)

16. (a) Informant G. W. Warren

(b) Address Matthews Mo. R. F. D.

17. (a) Burial (b) Date thereof 8/6/43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sikeston, Mo

18. (a) Signature of funeral director H. W. Albritton

(b) Address Sikeston

19. (a) 8-6-43 (b) Louis Largent  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 3  
year 1943 hour 3 minute 30 p. M.

21. I hereby certify that I attended the deceased from 8/1/43  
to 8/3/43, 1943  
that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Bitten by black widow spider

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions 194  
(Include pregnancy within 3 months of death)

Major findings: 194

Of operations \_\_\_\_\_

Of autopsy 99

Duration \_\_\_\_\_

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) \_\_\_\_\_

(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)

(e) Means of injury \_\_\_\_\_

23. Signature Dr. M. C. Mills (M. D. or other) MD

Address Sikeston Mo Date signed 8/4/43

1317

RECEIVED

District Health Office No. 2,

District File Number 8-43-1106

Date Filed 8-24-53

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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

*A. W. Albritton*

Licensed Embalmer No. 4210

P. O. Address Sikeston, 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, fact should be so stated above.