

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34292

State File No. ....

OCT 25 1943 / 3

Registration District No. ....

Primary Registration District No. 8007

Registrar's No. 297

1. PLACE OF DEATH:  
(a) County Butler  
(b) City or town Poplar Bluff  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Lucy Lee Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. 9 days  
In this community Life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Butler  
(c) City or town Rural - Broseley  
(If outside city or town limits, write "RURAL")  
(d) Street No. Route 1, Broseley  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country .....

3. (a) PRINT FULL NAME Shirley Jean Warren  
3. (b) If veteran, name war ..... 3. (c) Social Security No. ....

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife ..... 6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased May 31, 1935  
(Month) (Day) (Year)

8. AGE: Years 8 Months 4 Days 7 If less than one day hr. min.

9. Birthplace Broseley Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Schoolgirl

11. Industry or business

12. Name Elmer Warren

13. Birthplace Broseley Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Ma Head

15. Birthplace Poplar Bluff Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Elmer Warren

(b) Address Rt. 1, Broseley, Missouri

17. (a) Burial (b) Date thereof Oct. 3, 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mole Hill Cemetery

18. (a) Signature of funeral director Greer Croy  
(b) Address Poplar Bluff, Missouri

19. (a) 10-9-43 (b) Bees Thune  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 2  
year 1943 hour 5:00 minute A. M.  
21. I hereby certify that I attended the deceased from Sept. 22,  
1943, to October 2, 1943;  
that I last saw her alive on October 2, 1943;  
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia  
nephritis (acute)  
acute throat  
Other conditions (include pregnancy within 3 months of death) .....

Duration  
5 days  
6 days  
10 days

Major findings:  
Of operations .....  
Of autopsy .....

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 J. A. Meeker (M. D. or other) .....  
Address Poplar Bluff, Mo. Date signed 10-4-43

MOTHER FATHER

72

RECEIVED

District Health Office No.

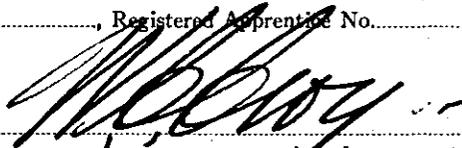
District File Number 1043-1

Date Filed 10-20-

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. 3474

P. O. Address Poplar Bluff, Miss

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. *1102*

Registration District No. *73*

Primary Registration District No. *3007*

Registrar's No. *297*

1. PLACE OF DEATH:

(a) County *Butler*  
(b) City or town *Paplar Bluff*  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution (Specify whether  
In this community years, months or days)

3. (a) PRINT FULL NAME

*Shiley Jean Warren*

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex *F*

5. Color or race *w*

6. (a) Single, widowed, married, divorced *S*

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive

7. Birth date of deceased

*May 31 1901*  
(Month) (Day) (Year)

8. AGE: Years *8* Months *7* Days *11* less than one day min.

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

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name (City, town, or county) (State or foreign country)

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

16. (a) Informant (b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director (b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County  
(c) City or town (If outside city or town limits, write "RURAL")  
(d) Street No. (If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Dec* year *1943* hour minute M.

21. I hereby certify that I attended the deceased from that I last saw him alive on and that death occurred on the date and hour stated above. Immediate cause of death *Uremia*

*nephritis acute*  
Due to

Due to *acute throat streptococci*  
Other conditions *no chronic nephritis*  
(Include pregnancy within 3 months of death)

Major findings: Of operations Of autopsy *115b*

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) (c) Means of injury

23. Signature (M. D. or other) Address Date signed

SUPPLEMENTARY

MOTHER FATHER

34292