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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35507**

LED NOV 6 1943

Registration District No. **275**

Primary Registration District No. **3053**

Registrar's No. **23** 93

1. PLACE OF DEATH:

(a) County PHELPS

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

(c) Name of hospital or institution:
Rolla Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 16 Days (Specify whether years, months or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County PHELPS 81

(c) City or town ROLLA 2
(If outside city or town limits, write "RURAL") 2

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country _____ 7

3. (a) PRINT FULL NAME LOVIE WARINGTON

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 22
year 1943 hour 6 P.M. minute _____ M.

21. I hereby certify that I attended the deceased from Oct 5, 1943
to Oct 22, 1943 19____;

4. Sex FEMALE 5. Color or race WHT

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife THOMAS J. WARINGTON

6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased _____ (Month) (Day) (Year)

that I last saw him alive on 10/22/1943, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death Bilateral Myocardial infarction and general peritonitis

8. AGE:	Years	Months	Days	If less than one day
	<u>35</u>			_____ hr. _____ min.

Due to _____

Due to _____

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

9. Birthplace UN KNOWN MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSE WIFE

11. Industry or business _____

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER {

12. Name WILL KISSEE

13. Birthplace UN KNOWN 9
(City, town, or county) (State or foreign country)

14. Maiden name MARY RAND

15. Birthplace UN KNOWN 9
(City, town, or county) (State or foreign country)

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? _____

16. (a) Informant THOMAS J. WARINGTON (HUSBAND)

(b) Address ROY MONTVILLE MO.

17. (a) BURIAL (b) Date thereof 10-23-1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CENTRO BAPTIST

18. (a) Signature of funeral director Luan Evans

While at work _____ (Specify type of place)

Means of injury _____

23. Signature [Signature] (M. D. or other)

Address Rolla Mo Date signed 10/22/1943

(b) Address [Address]

19. (a) 10/22/1943 (b) [Signature]
(Date received local registrar) (Registrar's signature)

1092 (Licensed Embalmer's Statement on Reverse Side)

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

NOV 7 1943
6 10 AM
1943

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.....

Russell Barber

Licensed Embalmer No. *3848*

P. O. Address *mt Grove, Pa*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Nov
Registrar's No. 93

Registration District No. 275 Primary Registration District No. 3053

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

1. PLACE OF DEATH:
(a) County Phelps
(b) City or town Rolla
(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 _____ (Specify whether _____ years, months or days)

3. (a) PRINT FULL NAME Dorrie Warbington
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 m
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: (Month) _____ (Day) _____ (Year) _____
8. AGE: Years 35 Months _____ Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

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 _____ day _____ year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I first saw him _____ and that death occurred on the date and hour stated above. Immediate cause of death Bilateral pyelonephritis and general peritonitis Duration _____

Due to General condition.

Due to _____

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

Major findings: Of operations _____ 2512 OF PHYSICIAN
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) _____ (e) Means of injury _____

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

35507