

No. 2
8-43
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30896**

FILED OCT 7 1946

Registration District No. **187**

Primary Registration District No. **3038**

Registrar's No. **9# 6**

1. PLACE OF DEATH:

(a) County **Linn**
(b) City or town **Brookfield**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **53 yrs.** (Specify whether years, months or days)
In this community **53 yrs.**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Linn 58**
(c) City or town **Brookfield**
(If outside city or town limits, write "RURAL")
(d) Street No. **615 N Wood**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **14**
year **1946** hour **2** minute **45 p. M.**
21. I hereby certify that I attended the deceased from **March 2** **14**, 1946, to **Sept 14**, 1946
that I last saw her alive on **Sept 13**, 1946
and that death occurred on the date and hour stated above.

3. (a) PRINT FULL NAME **Laura Mae Warren**

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

4. Sex **Female** 5. Color of race **White** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **James Willard Warren** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: **May 30 1892**
(Month) (Day) (Year)

8. AGE: Years **53** Months **3** Days **14** If less than one day hr. min.

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

10. Usual occupation **At home**

11. Industry or business _____

12. Name **Charles B. Edgar**

13. Birthplace **St Catherine Mo**
(City, town or county) (State or foreign country)

14. Maiden name **Ella Patricia**

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

16. (a) Informant **Laura M Warren**
(b) Address **Brookfield Mo**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Sept 16 1946**
(Month) (Day) (Year)

(c) Place: burial or cremation **Resurgent V.M. Cemetery**

18. (a) Signature of funeral director **James Borden**
(b) Address **Brookfield Mo**

19. (a) **9-16-46** (b) **J. Brown**
(Date received local registrar) (Registrar's signature)

Immediate cause of death **Carcinoma of Bladder (Primary)** Duration **6 mo**

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

Major findings: Of operations **52 B**
Of autopsy _____

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. J. Potter** (M. D. or other) **P.O.**
Address **Brookfield Mo** Date signed **9-16-46**

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

MOTHER FATHER

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

DISTRICT HEALTH OFFICER
Cameron, Mo.

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 Homer Bawden

Licensed Embalmer No. 3295

P. O. Address Brookfield 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.