S. No. 2
I—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 27435

FILED AUG 20 1947

Registration District No. 2000 — Primary Registration District No. 2000 — Registrar's No. 685

1. PLACE OF DEATH:
(a) County: Greene
(b) City or town: Springfield 707 N Main (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Warnicke Nursing Home (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 10 months (Specify whether years, months or days)
In this community: one year

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

3. (a) PRINT FULL NAME: Emeline H. Warren
3. (b) If veteran, name war:
3. (c) Social Security No.: none
4. Sex: F
5. Color or race: W
6. (a) Single, widowed, married, divorced: Widowed
6. (b) Name of husband or wife: Joe Warren
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: Nov. (Month) 20 (Day) 1872 (Year)
8. AGE: Years 74 Months 8 Days 11 If less than one day hr. min.
9. Birthplace: Wisconsin (City, town, or county) (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Christian Hanson
13. Birthplace: Sweden (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: Sarah Kelly
15. Birthplace: Sweden (City, town, or county) (State or foreign country)
16. (a) Informant: Lon Warren
(b) Address: Springfield Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 8-3-47 (Month) (Day) (Year)
(c) Place: burial or cremation: Graceland Cemetery
18. (a) Signature of funeral director: W E Holman
(b) Address: Lebanon Mo.
19. (a) 8-2-47 (Date received local registrar) (b) W E Handley M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 31 year 1947 hour 8 minute 45 P.M.
21. I hereby certify that I attended the deceased from 7,16,47, 19, to 7,31,47, 19; that I last saw her alive on 7,31,47, 19; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Hemorrhage, cerebral	15 days
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations: N P
Of autopsy: D

PHYSICIAN — Underline the cause of 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? (Specify type of place)
While at work? (e) Means of injury: 0

23. Signature: J D Musick (M. D. or other)
Address: Springfield, Mo. Date signed: 8,2,47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

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 Dorsey M. Howe

Licensed Embalmer No. 4222

P. O. Address Lebanon, 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.