. No. 2
—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. 30314

FILED SEP 27 1948

Registration District No. ____ Primary Registration District No. 3038 Registrar's No. 79

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: 209 S. Clinton (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days) In this community: 14 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") 1
(d) Street No.: 209 S. Clinton (If rural, give location) 2
(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country: ____

3. (a) PRINT FULL NAME: Richard Lee Warren
3. (b) If veteran, name war: ✓
3. (c) Social Security No.: ✓
4. Sex: M
5. Color or race: W
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Solattia Warren
6. (c) Age of husband or wife if alive: 67 years
7. Birth date of deceased: Aug (Month) 18 (Day) 1872 (Year)
8. AGE: Years 76 Months 0 Days 26 If less than one day ____ hr. ____ min.
9. Birthplace: (City, town, or county) Mo (State or foreign country)
10. Usual occupation: Carpenter
11. Industry or business: ____
MOTHER FATHER
12. Name: James Jackson Warren
13. Birthplace: (City, town, or county) Mo (State or foreign country)
14. Maiden name: Malissa Allen
15. Birthplace: (City, town, or county) Mo (State or foreign country)
16. (a) Informant: Mrs Solattia Warren
(b) Address: Brookfield Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9-16-1948 (Month) (Day) (Year)
(c) Place: burial or cremation: Rose Hill Brkfld
18. (a) Signature of funeral director: Louis Flapper
(b) Address: Laclede Mo.
19. (a) 9-17-48 (Date received local registrar) (b) Walter Brown (Registrar's signature) 10

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. 13 day ____ year 1948 hour 11 minute 50 p. M.
21. I hereby certify that I attended the deceased from July 18, 1948, to Sept 13, 1948, that I last saw him alive on Sept 13, 1948, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic nephritis	6 mo.
Due to: arterial hypertension	years
Due to: —	
Other conditions (Include pregnancy within 3 months of death): —	

Major findings:
Of operations: —
Of autopsy: —

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: ____

23. Signature: H. T. Geffen (M. D. or other) Dr.
Address: Brookfield Mo Date signed 9-17-48.

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

DISTRICT HEALTH OFFICE
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 Louis E. Hopper

Licensed Embalmer No. 4261

P. O. Address Clarence, 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.