

FILED MAY 11 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11719**
Registrar's No. **138**

14
2

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

BIRTH NO. _____		REG. DIST. NO. <u>47</u>		PRIMARY REG. DIST. NO. <u>3008</u>		Registrar's No. <u>138</u>	
1. PLACE OF DEATH a. COUNTY <u>Callaway</u>				2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE <u>Indiana</u> b. COUNTY <u>Unk</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Fulton</u>		c. LENGTH OF STAY (In this place) <u>6 mo 24 d</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Gary</u>		979 102	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital No 7 2</u>				d. STREET ADDRESS (If rural, give location) <u>1428 Georgia St. 2</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Walter</u>		b. (Middle) <u>F.</u>		c. (Last) <u>WRENN.</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 22 1949</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>14 Nov 1887</u>	
9. AGE (In years last birthday) <u>61</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>8</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Arkansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Another WRENN</u>		13b. MOTHER'S MAIDEN NAME <u>Levenna Walker</u>		14. NAME OF HUSBAND OR WIFE <u>Elvena WRENN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unk</u>		16. SOCIAL SECURITY NO. <u>Unk</u>		17. INFORMANT'S SIGNATURE OR NAME. ADDRESS <u>State Hospital Records Fulton, Mo</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Haemorrhage</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Cerebral Arterio Sclerosis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>Unk</u> <u>331X</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>28 Sept</u> , 19 <u>48</u> , to <u>22 April</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>22 April</u> , 19 <u>49</u> , and that death occurred at <u>8.5 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>G.S. Waraich O M.D.</u>				23b. ADDRESS <u>Fulton, Mo</u>		23c. DATE SIGNED <u>22 April 49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>4-28-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>State Hosp - Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Fulton Mo</u>	
DATE REC'D BY LOCAL REG <u>April 27 - 1949</u>		REGISTRAR'S SIGNATURE <u>Martha Lawrence</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>4260</u> <u>Champ C. Weeks</u>		ADDRESS <u>Fulton Mo.</u>	

RECEIVED
District Health Officer No. 9,
District File Number
MAY 10 1949
Date Filed

VS
MAY 19 1960

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.....
..... Student Embalmer No.
working under my personal supervision.

Student
Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.