

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

5353

STATE FILE NUMBER

FILED MAR 5 1957

Registration District No. 170 Primary Registration District No. 3033 Registrar's No. 32

1. PLACE OF DEATH a. COUNTY <u>Laclede</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Laclede</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lebanon</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Lebanon</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Wallace Memo. Hosp.</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>McClure Addn.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>A</u> Last <u>Warren</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>20</u> Year <u>1957</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 16 1889</u>	9. AGE (In years last birthday) <u>67</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter &amp; Paper Hanger</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Springfield Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>James H. Warren</u>			14. MOTHER'S MAIDEN NAME <u>Missouri A. Scott</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>498-03-4471</u>	17. INFORMANT <u>Mrs. W. A. Warren</u> Address <u>Lebanon Mo.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage rt. side of brain</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>Hypertension</u>					INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Left hemiplegia</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		COUNTY _____ STATE _____
21. I attended the deceased from <u>20 Feb 57</u> to <u>20 Feb 57</u> and last saw her/him alive on <u>20 Feb 57</u> . Death occurred at <u>4:00</u> P. M. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Deponent title) <u>Paula Jenkins M.D.</u>			22b. ADDRESS <u>Lebanon Mo.</u>		22c. DATE SIGNED <u>2-22-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2/23/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lebanon</u>		23d. LOCATION (City, town, or county) (State) <u>Lebanon Mo.</u>	
24. FUNERAL DIRECTOR <u>S. R. Palmer</u> ADDRESS <u>Lebanon Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>2-23-1957</u>		26. REGISTRAR'S SIGNATURE <u>Hella L. Hays</u>	

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare Public Service  
300 1-56  
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

424

Received 3-4-57  
Laclede County Health Unit  
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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.....  
Signature of Student Embalmer

Signed S. R. Palmer  
.....

Licensed Embalmer No. 22

P. O. Address Libany

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.