

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-043031**  
STATE FILE NUMBER

FILED VS. NOV 19 1959 33  
 Registration District No. 3074 Primary Registration District No. 3074 Registrar's No. 207

1. PLACE OF DEATH a. COUNTY <b>Scott</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Mississippi</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Sikeston</b>			Length of stay in 1b <b>Life</b>		c. CITY OR TOWN <b>Rt. 1 Charleston</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Delta Community Hosp.</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>Rt. 1 Charleston</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Kenneth</b> Middle <b>Wayne</b> Last <b>Warren</b>				4. DATE OF DEATH Month <b>11</b> Day <b>1</b> Year <b>1959</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>10/22/59</b>		9. AGE (last birthday) IF UNDER 1 YEAR: Months <b>9</b> Days <b>9</b> IF UNDER 24 HR: Hours <b>9</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Infant</b>		11. BIRTHPLACE (City and state or country) <b>Sikeston, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
13a. FATHER'S NAME <b>Maurice Warren</b>			13b. MOTHER'S MAIDEN NAME <b>Hazel Presson</b>			14. NAME OF HUSBAND OR WIFE <b>Mrs. Hazel Warren, Rt. 1 Charleston Mo.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Hazel Warren, Rt. 1 Charleston Mo.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Circulatory Failure 3 days</b> DUE TO (b) <b>Temporarily</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input 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 _____ a.m. _____ p.m. Month, Day, Year _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <b>Oct. 22, 1959</b> , to <b>Nov 1, 1959</b> and last saw her <sup>him</sup> alive on <b>Nov 4, 1959</b> Death occurred at <b>2:00 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <i>[Signature]</i> (Degree or title)				22b. ADDRESS <b>Charleston Mo</b>			22c. DATE SIGNED <b>11/2/59</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11/2/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cemetery</b>			23d. LOCATION (City, town, or county) (State) <b>Charleston, Mo.</b>			
24. FUNERAL DIRECTOR <b>The Nunnelee Funeral Chapel</b> ADDRESS _____				25. DATE RECD. BY LOCAL REG. <b>11-12-59</b>		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Body WAS NOT EMBALMED, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

John D. Munnell

Licensed Embalmer No. 3851

P. O. Address Charleston

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.