DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 17 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16119

Registration District No. 356 — Primary Registration District No. 6137 — Registrar's No.

1. PLACE OF DEATH:
(a) County: Shannon
(b) City or town: Rural, Winona, Mo (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: None (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: No (Specify whether years, months or days) In this community: 2 Months

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

3. (a) PRINT FULL NAME: Claten Gayle Warren
3. (b) If veteran, name war: No
3. (c) Social Security No.: No
4. Sex: M
5. Color or race: W
6. (a) Single, widowed, married, divorced: Child
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: Jan, 12th 1947 (Month) (Day) (Year)
8. AGE: Years — Months 2 — Days 23 — If less than one day: hr. min.
9. Birthplace: Shannon County, Missouri (City, town, or county) (State or foreign country)
10. Usual occupation:
11. Industry or business:

FATHER
12. Name: Dolphus H. Warren
13. Birthplace: Shannon County, Mo (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Gloria W. Atkins
15. Birthplace: Shannon County, Missouri (City, town, or county) (State or foreign country)

16. (a) Informant: Dolphus H Warren
(b) Address: Winoma, Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4/6 47 (Month) (Day) (Year)
(c) Place: burial or cremation: Mt Zion Cem.
18. (a) Signature of funeral director: John F. [illegible]
(b) Address: Mountain View, Mo
19. (a) 4-10-47 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 5th year 1947 hour 5 minute 55 P. M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pneumonia	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN — Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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: [illegible] (M. D. or other)
Address: [illegible] Mo Date signed 4-8-47

306 (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.

Not Embalmed

Signed John F. [illegible]

Licensed Embalmer No. 2516

P. O. Address [illegible]

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. May

Registration District No. 336 Primary Registration District No. 6137 Registrar's No. 8

1. PLACE OF DEATH:
(a) County Shannon
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

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

3. (a) PRINT FULL NAME Claten G. 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 S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Jan (Month) 12 (Day) 1924 (Year)
8. AGE: Years 23 Months Days If less than one day hr. min.
9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April Day 5 year 1947 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Lobar Pneumonia	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy 108	

PHYSICIAN — Underline the cause to 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 Frank Hyde (M. D. or other)
Address Eminence Mo. Date signed 5-19-47

SUPPLEMENTARY

16119