MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

2372

1929

1. PLACE OF DEATH
County Livingston — Registration District No. 515 — File No.
Township Blue Mound — Primary Registration District No. 5683 — Registered No. 1
City Christine (No. ..... St. ..... Ward)

2. FULL NAME Cristina Warner
(a) Residence. No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. ~~Single, Married~~, Widowed or ~~Divorced~~ (*write* the word): Widowed

5a. ~~If Married~~, Widowed, or Divorced HUSBAND of ~~(or) WIFE of~~: Widowed

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Nov. 12 - 1848

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
80	2	0	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Ohio

PARENTS
10. NAME OF FATHER: Lewis Johnson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Ohio
12. MAIDEN NAME OF MOTHER: unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): unknown

14. INFORMANT: C. E. Warner
(Address): Hawn Mo R 1

15. FILED 1/14, 1929 — T. R. Fullerton, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Jan 12 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to Jan 12, 1929, that I last saw her alive on Jan 10, 1929, and that death occurred, on the date stated above, at 7 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Influenza

11 Ds (duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (SECONDARY) 11 Ds (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? —
DID AN OPERATION PRECEDE DEATH? no. DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) A. Collier, M. D
Jan 14, 1929 (Address) Chillicothe Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Blue Mound — DATE OF BURIAL: 1-14 1929

20. UNDERTAKER: F. B. Norman — ADDRESS: Chillicothe Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.