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

Do not use this space. 12854

B. H.

File No. 1 12155

Registered No. 1753

1. PLACE OF DEATH

County: Jackson — Registration District No. 399

Township: Kan — Primary Registration District No. 10

City: K.C. Mo. (No. 1107 East Mo Ave, St. ..... Ward)

2. FULL NAME Fred Warner

(a) Residence. No. 1107 East Mo, St., ... Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Josie Warner

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug-19-1873

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
56	8	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(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) Missouri

PARENTS

10. NAME OF FATHER No Record

11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) No record

12. MAIDEN NAME OF MOTHER No record

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) No record

14. INFORMANT Josie Warner
(Address) 1107 - E - Mo. Ave

15. FILED 4/23, 1930 M M. Crowe, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-22, 1930

17. I HEREBY CERTIFY, That I attended deceased from Deputy Coroner ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 8 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic myocarditis
1 2 4 8
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Cirrhosis Liver
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED? 1261
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS? Autopsy
(Signed) Stanley McHaney, M. D.
4/22, 1930 (Address) Deputy Coroner

*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: Forest Hill — DATE OF BURIAL: Apr-24-1930

20. UNDERTAKER: Mrs. C. L. Jordan — ADDRESS: K.C. 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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD