REC'D APR 15 1939

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

11029
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson — Registration District No. 396
(b) Township ~~Fort Osage~~ — Primary Registration District No. 4233 — Registered No.
(c) City Buckner — (d) Street No. ..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. 7 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 652 Oscar Henry Warnex
(a) Residence, No. Buckner, Missouri St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word): single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: none

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): April 19, 1904

7. AGE

| YEARS | MONTHS | DAYS | If LESS than 1 day, ....hrs. or ....min. |
|---|---|---|---|
| 34 | 10 | 14 | |

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.: Farmer
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Wellington Missouri 0

FATHER
13. NAME: William Warnex 0
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Wellington Missouri 0

MOTHER
15. MAIDEN NAME: Mattie Barker
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Odessa Missouri

17. INFORMANT (ADDRESS): Mrs. Mattie Warnex Buckner, Missouri

18. BURIAL, CREMATION, OR REMOVAL
PLACE Buckner DATE March 5, 1939

19. FUNERAL DIRECTOR (NAME) Vernon M. Reppert
(ADDRESS) Buckner, Missouri

20. FILED Mar 3, 1939 John W Robinson
Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): March 3, 1939

22. I HEREBY CERTIFY, That I attended deceased from Feb 13, 1939, to Mar 3, 1939
I last saw him alive on Mar 2, 1939. Death is said to have occurred on the date stated above, at 2 p.m.
The principal cause of death and related causes of importance were as follows:

| | Date of onset |
|---|---|
| Emphysema | |
| | X |

Other contributory causes of importance:
Tuberculous rib

Name of operation Drainage Date of Feb
What test confirmed diagnosis? Clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? X Date of injury X, 19
Where did injury occur? X
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury X
Nature of injury X

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify X
(Signed) John W. Robinson, M. D.
(Address) Buckner, Mo

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Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, PERMANENT RECORD

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.

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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, Vernon M. Reppert, or by

Registered Apprentice No. ....., working under my personal supervision.

Signed V. M. Reppert

Licensed Embalmer No. 2321

P. O. Address Buckner, Missouri

**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 this body is not embalmed, above space should be left blank.**

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

11029
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson — Registration District No. 396
(b) Township — Primary Registration District No. 4232 — Registered No.
(c) City Buckner — (d) Street No. ..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Oscar Henry Warney
(a) Residence, No. ..... St. ☐ ..... (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

## PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) |
|---|---|---|
| m | W | S |

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

| 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ....hrs. or ....min. |
|---|---|---|---|---|
| | 34 | 10 | 14 | |

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE ..... DATE ....., 19....

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED May 9, 1939 John W Robertson
Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3 - 3, 1939

22. I HEREBY CERTIFY, That I attended deceased from ....., 19.... to ....., 19....
I last saw h..... alive on ....., 19.... Death is said to have occurred on the date stated above, at ..... m.
The principal cause of death and related causes of importance were as follows:

Empyemia Tuberculosis — Date of onset

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Other contributory causes of importance:
Tuberculosis - rib

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19....
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) John W. Robertson, M. D.
(Address) Buckner Mo

SUPPLEMENTARY

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

MAY 17 1939