

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

18987
Do not use this space.

REC'D JUN 20 1939

1. PLACE OF DEATH

(a) County Johnson Registration District No. 431
 (b) Township Warrensburg Primary Registration District No. 3023
 (c) City Warrensburg (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

(a) Residence, No. 653 Lenora Harned St. 515 N. Washington (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 <u>Fe</u>	4. COLOR OR RACE <u>Wh</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>widow</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>W. P. Harned</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>May 4, 1866</u>		
7. AGE YEARS <u>73</u>	MONTHS <u>0</u>	DAYS <u>10</u>
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>housewife</u>		
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) <u>Speed Cooper Co. Mo.</u>		
13. NAME <u>Tom Parrish</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>UNKNOWN</u>		
15. MAIDEN NAME <u>Mary Jane Waller</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>UNKNOWN</u>		
17. INFORMANT (ADDRESS) <u>Miss Marcia Harned 515 N. Washington Warrensburg Mo.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Dunlap Cem. Cooper Co. Mo. DATE <u>May 16, 1939</u></u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>W. F. Wilcox Funeral Service Warrensburg Mo.</u>		
20. FILED <u>May 15, 1939</u> <u>Earl Bentley</u> Local Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 14, 1939

22. I HEREBY CERTIFY, That I attended deceased from Jan. 1935, to May 14, 1939, 1939
 I last saw her alive on May 15, 1939. Death is said to have occurred on the date stated above, at 5 P. m.
 The principal cause of death and related causes of importance were as follows:
Cornley Accidion
 Date of onset _____

Other contributory causes of importance:
abdominal pain of 3 year standing

Name of operation _____ Date of _____
 What test confirmed diagnosis? Chung Was there an autopsy? no

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? no
 If so, specify _____
 (Signed) L. J. Schofield, M. D.
 (Address) Warrensburg, Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A 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 importa.

942

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 6/8/39

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.

Signed *Amel C. Lupis*

Licensed Embalmer No. *3053*

P. O. Address *Warrensburg Mo.*

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.

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1. PLACE OF DEATH

(a) County Johnson Registration District No. 431

(b) Township _____ Primary Registration District No. 3023 Registered No. _____

(c) City Warrensburg (d) Street No. _____ St. _____

(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 Lenora Harned

(a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED wid

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.

73 0 10

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 _____ 19 _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 14 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:

Coronary Occlusion Date of onset _____

no evidence the tumor was malignant

L. Schofield

Other contributory causes of importance: Abdominal tumor of 5 yrs standing

Name of operation _____ Date of _____

What test confirmed diagnosis? 942 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) L. J. Schofield, M. D.

(Address) Warrensburg 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.

Local Registrar.

