

Registration District No. **53** **FILED OCT 11 1940**

Registration District No. **3005** Registrar's No. **37**

1. PLACE OF DEATH:
(a) County **Bates**
(b) City or town **Rich Hill Missouri**
(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 **4 years** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Francis Warnock**
3. (b) If veteran, name war **X** **3. (c) Social Security** No. **X**

4. Sex **m** **5. Color or race** **W** **6. (a) Single, widowed, married, divorced** **married**
6. (b) Name of husband or wife **Cora Warnock** **6. (c) Age of husband or wife if alive** _____ years
7. Birth date of deceased **June 1, 1868**
(Month) (Day) (Year)

8. AGE: Years **72** Months **3** Days **8** If less than one day _____ hr. _____ min.

9. Birthplace **Kentucky** (City, town, or county) (State or foreign country)

10. Usual occupation **retired farmer**

11. Industry or business _____

12. Name **Wesley Warnock**

13. Birthplace **Ky.** (City, town, or county) (State or foreign country)

14. Maiden name **Fannie Warnock** (City, town, or county) (State or foreign country)

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Cora Warnock**

(b) Address **Rich Hill Missouri**

17. (a) _____ **(b) Date thereof** **Sep. 10/40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Crescent Hill-Adrian Mo.**

18. (a) Signature of funeral director **Booth Funeral Home**

(b) Address **Butler Missouri**

19. (a) **Sep. 10, 1940** **(b) Claude J. Allen**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **Bates**
(c) City or town **Rich Hill Mo.**
(If outside city or town limits write "RURAL")
(d) Street No. **Cedar St.** (If rural, give location)
(e) If foreign born, how long in U. S. A.? **life** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sep.** day **9**
year **1940** hour **6:25 AM** minute _____ M.

21. I hereby certify that I attended the deceased from _____
that I first saw him **in** _____
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Due to _____
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

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? _____

While at work? _____ (Specify type of place)
(a) Means of injury _____
Signature _____ (M. D. or other)
Address _____ Date signed **9-10-40**

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

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

9321

RECEIVED
District Health Officer No. 7,
District File Number 10-40-1452
Date Filed 10-9-40

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

Signed John G. Underwood
Licensed Embalmer No. 3585
P. O. Address Butler 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **31332**

Registration District No. **53**

Primary Registration District No. **3005**

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH

(a) County **Bates**
(b) City or town **Rich Hill Mo**
(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
In this community (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Francis Harroch**

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, divorced **m**

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years **72** Months **3** Days **8** If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name (City, town, or county) (State or foreign country)

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)

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) If foreign born, how long in U. S. A.?..... years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **Sept** day **9** year **1900** hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw h..... alive on..... and that death occurred on the date and hour stated above;

Immediate cause of death **Myocarditis**

Angrene of foot

Due to.....

Due to **Arteriosclerosis**

Other conditions..... (Include pregnancy within 3 months of death)

Major findings: Of operations..... **93 P'**

Of autopsy.....

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?

While at work? (Specify type of place) (e) Means of injury.....

23. Signature **Wm J. Allen** (M. D. or other.....)

Address **Rich Hill Mo** Date signed **10/16/00**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

1870

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31382

Registrar's No. 127

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 23

Primary Registration District No. 3005

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Bates
(b) City or town Rich Hill
(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)

3. (a) PRINT FULL NAME Francis W. Harnock

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 m

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 72 Months 3 Days 8 If less than one day _____ hr _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) _____ (Day) _____ (Year)

(c) Place of burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)

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) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH _____ month _____ day _____ 9
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Date _____
Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Claude Allen (M. D. or other) _____

Address Rich Hill _____ Day signed _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

