U. S. No. 21-11-10-39
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Rev. 5-17-39
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FILED NOV 25 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 36490

Registration District No. 7 7 7 Primary Registration District No. 4479 Registrar's No.

1. PLACE OF DEATH:
(a) County: Saline
(b) City or town: Slater
(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: 3 (Specify whether years, months or days)
In this community: 14 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Saline
(c) City or town: Slater (If outside city or town limits, write "RURAL")
(d) Street No.: 132 West Harold (If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: Flora Lewis Warner

3. (b) If veteran, name war: ✓

3. (c) Social Security No.: ✓

4. Sex: Female

5. Color or race: White

6. (a) Single, ~~widowed~~, married, divorced: Single

6. (b) Name of husband or wife: ✓

6. (c) Age of husband or wife if alive: ✓ years

7. Birth date of deceased: December 9 (Month) 1856 (Day) (Year)

8. AGE: Years 83 Months 9 Days 28 If less than one day ____ hr. ____ min.

9. Birthplace: Iowa Point Doniphan Co. Kansas (City, town, or county) (State or foreign country)

10. Usual occupation: House work

11. Industry or business: ✓

FATHER
12. Name: Phillip Warner
13. Birthplace: Ohio (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Ella A. Lynn
15. Birthplace: Saline Co. Mo (City, town, or county) (State or foreign country)

16. (a) Informant: Jones Warner
(b) Address: Slater Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10-9-40 (Month) (Day) (Year)
(c) Place: burial or ~~cremation~~: Slater Cemetery Mo

18. (a) Signature of funeral director: Jones & Salger
(b) Address: Slater Mo

19. (a) 10-9-40 (Date received local registrar) (b) W. M. Tuttle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day October year 1940 hour 11 minute 30 A. M.

21. I hereby certify that I attended the deceased from March, 1940, to Sept-, 1940, that I last saw h-e alive on Sept-5-, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Interstitial Nephritis

Due to: Senility.

Due to: ____

Other conditions: ____
(Include pregnancy within 3 months of death)

Major findings:
Of operations: ____
Of autopsy: ____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

23. Signature: M. L. Duggins (M. D. or other) ✓
Address: Slater, Mo. Date signed: 10/8/40

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
District Health Officer No. 8,
District File Number 11-13-46
Date Filed

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 Jas E Jones

Licensed Embalmer No. 3143

P. O. Address Slater 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.