

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

43671

State File No. ~~777~~ 13

Registrar's No. 13

JAN 25 1949
Registration District No. 2784

Primary Registration District No. 2784

1. PLACE OF DEATH:

(a) County Reynolds
(b) City or town Lesterville, rural
(c) Name of hospital or institution: near Mayberry
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community life years, months or days 2

3. (a) PRINT FULL NAME Carolyn Laverne Warnecke

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

4. Sex fem 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 October 31, 1940
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 8 hr. _____ min.

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

10. Usual occupation none

11. Industry or business _____

12. Name Emory Warnecke

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

14. Maiden name Edna Fisher

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

16. (a) Informant Emory Warnecke

(b) Address Annapolis Mo.

17. (a) Burial (b) Date thereof 11/8/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Annapolis Mo.

18. (a) Signature of funeral director Norman White & Sons

(b) Address 127 White Ironton Mo.

19. (a) Dec 14/40 (b) C. M. Gilpatrick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Reynolds
(c) City or town rural
(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 Nov. day 8th.
year 1940 hour 7 minute 00 A.M.

21. I hereby certify that I attended the deceased from 11/7-40
19 _____ to 11/8/1940
that I last saw her alive on 11/7-40 19 _____
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho pneumonia
Duration 7

Due to Probable infection
one at birth

Due to _____
Other conditions (Include pregnancy within 3 months of death) 1974

Major findings: Of operations _____
Of autopsy _____
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? 72

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

23. Signature [Signature] (M. D. or other) _____
Address [Address] Date signed 11/15/40

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

MOTHER FATHER

RECEIVED

District Health Officer No. 5,

District File Number 14187

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.....

Licensed Embalmer No.....

P. O. Address.....

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.