

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

4771
Do not use this space.

1. PLACE OF DEATH

(a) County Worth Registration District No. 903
(b) Township Smith Primary Registration District No. 4544
(c) City Albendale or (d) Street No. _____
(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

SAPHONIA FLORA WARNER
(a) Residence, No. _____ 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 <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>William Warner</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Nov 14 1862</u>		
7. AGE	YEARS <u>77</u>	MONTHS <u>10</u>
	DAYS <u>7</u>	IF LESS than 1 day, _____ hrs. or _____ min.
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) <u>Albendale Mo</u>		
FATHER	13. NAME <u>Robert R. Popertson</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Tenn</u>	
MOTHER	15. MAIDEN NAME <u>Saloma Wood</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ohio</u>	
17. INFORMANT (ADDRESS) <u>Opal Wilkinson Albendale Mo.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Albendale Cemetery</u> DATE <u>Sept 23 1940</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Sam Bess Denver, 116</u>		
20. FILED <u>Jan 29 1941</u> <u>Clifford Hays</u> Local Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 21 1940

22. I HEREBY CERTIFY, That I attended deceased from Sept 15 1940 to Sept 21 1940
I last saw him alive on Sept 21 1940. Death is said to have occurred on the date stated above, at 10:00 a.m.
The principal cause of death and related causes of importance were as follows:
Acute Myocarditis
93%
Other contributory causes of importance:
Dysrhythmic Arrhythmia
Arterio Sclerosis

Name of operation _____ Date of operation _____
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) O. H. Bullington M. D.
(Address) Bedding Town

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.....

J P Bram

Licensed Embalmer No. *2947*

P. O. Address *Denver 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.