

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registrar's No.

FILED OCT 8 1942

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County Pettis
 (b) City or town Sedalia
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution O. Bethwell Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 Day Specify whether
 In this community 3 yrs years, months or days

3. (a) PRINT
FULL NAMEOtto Harry Warner

3. (b) If veteran,

name war.

3. (c) Social Security

No.

499-14-5667

4. Sex

Male

5. Color or

race

White

6. (a) Single, widowed, married,

1 divorced, married

6. (b) Name of husband or wife

Hazel

6. (c) Age of husband or wife if

alive 42 years

7. Birth date of deceased

(Month)

(Day)

(Year)

July 14 1900

8. AGE:

Years

Months

Days

If less than one day

42 2 16 hr. min.

9. Birthplace

Wanersburg Mo
(City, town, or county) (State or foreign country)

10. Usual occupation

Repair Work

11. Industry or business

Garage

12. Name

Otto Warner

13. Birthplace

Lowell Ohio
(City, town, or county) (State or foreign country)

14. Maiden name

Sallie Nelson

15. Birthplace

Wanersburg Mo
(City, town, or county) (State or foreign country)

16. (a) Informant

Mrs Otto Warner

(b) Address

512 Wilkerson

17. (a)

Burial
(Burial, cremation, or removal)

(b) Date thereof

10/2/42
(Month) (Day) (Year)

(c) Place: burial or cremation

Wanersburg Mo

18. (a) Signature of funeral director

Mc Laughlin Bur

(b) Address

Sedalia Mo

19. (a)

10/1/42
(Date received local registrar)

(b)

Mrs Anna Berger
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Pettis
 (c) City or town Sedalia
 (If outside city or town limits, write "RURAL")
 (d) Street No. 512 Wilkerson
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 30
 year 1942 hour 14 minute 30 A.M.

21. I hereby certify that I attended the deceased from Aug 1st
1942 to Sept 30 1942

that I last saw him alive on Aug 2/9 1942
 and that death occurred on the date and hour stated above.

Immediate cause of death Subarachnoid hemorrhage Duration

Due to Anger and
hemorrhage

Due to Systolic hypertension
probably due to mitral

Other conditions probably due to mitral
 (Include pregnancy within 3 months of death)

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? ✓

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

23. Signature A. C. Campbell (M. D. or other)

Address Sedalia Mo Date signed Oct 4 1942

1022 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 10-7-42

JUN 26 1956

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. 3745

P. O. Address Sedalia 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, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **31049**
Registrar's No. **336**

Registration District No. **274**

Primary Registration District No. **3052**

1. PLACE OF DEATH:

(a) County **Pettis**
(b) City or town **Sedalia**
(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 **etto Harry Warner**

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 _____

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

7. Birth date of deceased _____ (Month) **July** (Day) **14** (Year) **1942**

8. AGE: Years **42** Months **2** Days **16** If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____ Year **1942** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 **Edema hemorrhagic**
Duration **probably due to prolonged poisoning from morphine tabs.**
Due to **careful withdrawal of morphine tabs in paroxysm - resulting pneumonia**
Other condition _____ (Include pregnancy within 3 months of death)

Major findings: Of operations **no operation** Of autopsy **no**
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? _____

While at work? _____ (Specify type of work) (c) Means of injury _____
23. Signature **Dr. J. C. Campbell** (M. D. or other) _____
Address **Sedalia Mo.** Date signed **10-23-42**

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

SUPPLEMENTARY

[The page contains extremely faint, illegible text, likely a scan of a document with very low contrast or significant fading. The text is organized into several paragraphs, but the individual words and sentences cannot be discerned.]