S. No. 2
M—2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED AUG 10 1945

25306

State File No.

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 104

1. PLACE OF DEATH:

(a) County Vernon

(b) City or town Rural Washtn. Twp.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hosp. No 3. 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 26 yr. 1 mo. 15 da (Specify whether
In this community Same time
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Osage 108

(c) City or town Westphalia 0
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) Citizen of foreign country? No. 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME John Werner

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife none

6. (c) Age of husband or wife if alive none years

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

8. AGE:

Years	Months	Days	If less than one day
63	-	-	hr. min.

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

10. Usual occupation Farming

11. Industry or business

FATHER
12. Name Charles Werner
13. Birthplace ~~Germany~~ ~~No~~ 4
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name unknown
15. Birthplace Germany 4
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records
(b) Address Nevada Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jul 17 1945
(Month) (Day) (Year)
(c) Place: burial or cremation Hospital Cemetery

18. (a) Signature of funeral director Allen V Hays
(b) Address Nevada Mo.

19. (a) 7-17-45 (Date received local registrar) (b) Hazel B. Bevis (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 15
year 1945 hour 4:10 minute P M.

21. I hereby certify that I attended the deceased from 6-1-45, 19..., to 7-15-, 1945
that I last saw him alive on July 15, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Meningitis, Secondary to Phlebitis of Rt. Lower Limb.

Due to Causative organism unknown

Due to

Other conditions 8/10
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy Petechial condition of brain surface

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 R B Lester (M. D. or other)

Address Nevada Mo. Date signed 7-15-45

1331

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7
District File No. 7-45-760
Date Filed 8-9-45

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 Not

..... Registered Apprentice No. .....,

working under my personal supervision.

Signed Allen E. Hays

Licensed Embalmer No. 1968

P. O. Address Nevada 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.

S. No. 2B
M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. ..... AUG

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 104

1. PLACE OF DEATH:

(a) County Vernon

(b) City or town Rural Washington Twp.
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State ..... (b) County .....

(c) City or town .....
(If outside city or town limits, write "RURAL")

(d) Street No. 1
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME John Werner

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 S

6. (b) Name of husband or wife .....

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

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

8. AGE: Years 63 Months Days If less than one day ..... hr. ..... min.

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

10. Usual occupation .....

11. Industry or business .....

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

MOTHER
14. Maiden name .....
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) 8-15-45 (Date received local registrar) (b) Hazel B. Beuick (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Jul Day 15
year 1945 hour ..... minute ..... M.

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

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions ..... (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? ..... (Specify type of place)
While at work? ..... (e) Means of injury .....

23. Signature ..... (M. D. or other) .....
Address ..... Date signed .....

SUPPLEMENTARY

1945
S-25306