

FILED JUN 6 1946  
Registration District No. 385

Primary Registration District No. 3039

Registrar's No. 84

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

1. PLACE OF DEATH:

(a) County Linn

(b) City or town Marceline  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 27 years (Specify whether years, months or days)

In this community: 27 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Linn

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

(d) Street No. 121 E. State  
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country: \_\_\_\_\_

3. (a) PRINT FULL NAME John Davis Warner

3. (b) If veteran name war: \_\_\_\_\_

3. (c) Social Security No. 709-18-4079

4. Sex m 5. Color or race w

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

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

6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased August 18 1879  
(Month) (Day) (Year)

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

66 9 12 hr. min.

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

10. Usual occupation R.R. Engineer, Retired

11. Industry or business Santa Fe R.R.

MOTHER FATHER

12. Name Erastus Herman Warner

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

14. Maiden name Lettie Jane Anderson

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

16. (a) Informant Mrs John Warner Sr.

(b) Address Marceline Mo

17. (a) Burial (b) Date thereof June 1 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation mt Olive

18. (a) Signature of funeral director James Mangler

(b) Address Marceline Mo

19. (a) 6-1-46 (b) L. Shelton  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 30  
year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from May 1 1946 to May 25 1946  
that I last saw him alive on May 25 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Mitral Insufficiency  
hypertension  
arteriosclerosis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

Major findings: \_\_\_\_\_

Of operations: \_\_\_\_\_

Of autopsy: 17

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? \_\_\_\_\_

23. Signature P. J. Patrick (M.D. or other) 17  
Address Marceline Mo Date signed 5-30-46  
(Specify type of place) (e) Means of injury \_\_\_\_\_

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

**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: *Blanche Mary Klee*

Licensed Embalmer No. *1909*

P. O. Address *Marceline M.*

**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.**