

FILED JUN 6 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15597

State File No.

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 488

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| 1. PLACE OF DEATH a. COUNTY <u>Greene</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) <u>Springfield</u> | | c. CITY (If outside corporate limits, write RURAL and give township) <u>Springfield</u> | |
| c. LENGTH OF STAY (In this place) <u>26 years</u> | | d. STREET ADDRESS (If rural, give location) <u>2136 N. National Avenue</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Rogers Rest Home</u> <u>902 West Walnut</u> | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>ANNA</u> | | b. (Middle) _____ c. (Last) <u>WERNER</u> | |
| 4. DATE OF DEATH (Month) (Day) (Year) <u>May 31, 1949</u> | | 5. SEX <u>Female</u> | |
| 6. COLOR OR RACE <u>White</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> | |
| 8. DATE OF BIRTH <u>Dec. 19, 1866</u> | | 9. AGE (In years last birthday) <u>82</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Germany</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>William Walter</u> | | 13b. MOTHER'S MAIDEN NAME <u>unknown</u> | |
| 14. NAME OF HUSBAND OR WIFE <u>Adolph Werner</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> | |
| 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>E.G. Walter, Springfield, Mo.</u> | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. | | | |
| 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic val heart lesion</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> |
| ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>superior</u> DUE TO (c) <u>stability</u> | | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>neurocytosis</u> | | | |
| 19a. DATE OF OPERATION <u>None</u> | | 19b. MAJOR FINDINGS OF OPERATION <u>None</u> | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u> | |
| 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Springfield</u> | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Springfield, Mo.</u> | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>3:15 P.M.</u> | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 21f. HOW DID INJURY OCCUR? <u>None</u> | | | |
| 22. I hereby certify that I attended the deceased from <u>4/20</u> , 19 <u>49</u> , to <u>5/31</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>2/30</u> , 19 <u>49</u> , and that death occurred at <u>3:15 P.M.</u> , from the causes and on the date stated above. | | | |
| 23a. SIGNATURE (Degree or title) <u>J. Freeman M.D. Citizen</u> | | 23b. ADDRESS <u>Springfield, Mo.</u> | |
| 23c. DATE SIGNED <u>5-2-49</u> | | 24. LOCATION (City, town, or county) (State) <u>Springfield, Mo.</u> | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24b. DATE <u>6/2/1949</u> | |
| 24c. NAME OF CEMETERY OR CREMATORY <u>Maple Park</u> | | 24d. LOCATION (City, town, or county) (State) <u>Springfield, Mo.</u> | |
| DATE REC'D BY LOCAL REG. <u>6/2/49</u> | | REGISTRAR'S SIGNATURE <u>W.E. Handley M.D.</u> | |
| 25. FUNERAL DIRECTOR'S SIGNATURE <u>W.C. Stone</u> | | ADDRESS <u>Springfield, Mo.</u> | |

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

Ralph H. Thieme

Signed _____
Student Embalmer

Licensed Embalmer No. 3681

P. O. Address Springfield, 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.