

FILED AUG 22 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26051

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 11 PRIMARY REG. DIST. NO. 5044 Registrar's No. 55

| | | | |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Barry</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Barry</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural-Washburn Twp.</u> | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural-Washburn Twp.</u> | |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Rt. 1, Cassville - 4 mi. South</u> | | d. STREET ADDRESS (If rural, give location) <u>4 mi. South of Cassville</u> | |
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>John</u> b. (Middle) <u>Shipley</u> c. (Last) <u>Varner</u> | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>August 3, 1949</u> |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>May 20, 1859</u> |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 9b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u> | 9. AGE (In years last birthday) <u>90</u> IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 2 HRS. Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u> | 11. BIRTHPLACE (State or foreign country) <u>Tenn.</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13a. FATHER'S NAME <u>William M. Varner</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>Catherine W. Shipley</u> | | 14. NAME OF HUSBAND OR WIFE <u>Maggie J. Varner</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. _____ | |
| 17. INFORMANT'S SIGNATURE OR NAME _____ | | ADDRESS _____ | |
| 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, asthma, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | |
| 19a. DATE OF OPERATION _____ | | 19b. MAJOR FINDINGS OF OPERATION _____ | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____ | |
| 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____ | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 21f. HOW DID INJURY OCCUR? _____ | | | |
| 22. I hereby certify that I attended the deceased from <u>August 28, 1949</u> , to <u>Aug. 2, 1949</u> , that I last saw the deceased alive on <u>Aug 2, 1949</u> , and that death occurred at <u>9:30 m.</u> , from the causes and on the date stated above. | | | |
| 23a. SIGNATURE (Degree or title) <u>Glenn H. Salzer M.D.</u> | | 23b. ADDRESS <u>Cassville Mo</u> | |
| 23c. DATE SIGNED <u>aug. 8</u> | | 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | |
| 24b. DATE <u>8-5-49</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>Washburn Prairie</u> | |
| 24d. LOCATION (City, town, or county) (State) <u>Barry County, Mo.</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>W.C. Koon</u> | |
| 25. ADDRESS <u>Cassville, Mo.</u> | | DATE REC'D BY LOCAL REG. <u>Aug 8-1949</u> | |
| REGISTRAR'S SIGNATURE <u>Grace Williams</u> | | 10 _____ | |

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED AUG 15 1949
District Health Office No. 6,
District File Number 849-940
Date Filed 8-18-49

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.

Student
Student Embalmer

Signed W. C. Koon

Licensed Embalmer No. 4359

P. O. Address Cassville, 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.