

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8748**

FILED MAR 23 1953

BIRTH NO.		REG. DIST. NO. 30	PRIMARY REG. DIST. NO. 5103	Registrar's No. 13
1. PLACE OF DEATH a. COUNTY BENTON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY BENTON		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Warsaw-Rural		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Warsaw-Windsor		
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location)		
d. FULL NAME OF HOSPITAL OR INSTITUTION "None" M-N-Warsaw		e. STREET ADDRESS Rural 3-M-N-Warsaw		
3. NAME OF DECEASED (Type or Print) a. (First) Florence b. (Middle) LAY c. (Last) KNIGHT		4. DATE OF DEATH (Month) (Day) (Year) MAR 14 1953		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Nov. 3, 1880	9. AGE (In years last birthday) 72 if under 1 year: Months 4 Days 11 if under 24 hrs. Hours Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and State or Foreign Country) Warsaw, Missouri
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME James H. Lay		
13b. MOTHER'S MAIDEN NAME Julia Park's		14. NAME OF HUSBAND OR WIFE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No		17. INFORMANT'S SIGNATURE OR NAME, ADDRESS Julia Knight Warsaw
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Semility		ANTECEDENT CAUSES		unk
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (b)		
DUE TO (c) 0		II. OTHER SIGNIFICANT CONDITIONS Cerebral Atherosclerosis		unk
Conditions contributing to the death but not related to the disease or condition causing death. Generalized Arteriosclerosis				unk
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 3-34 X		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT (Specify) SUICIDE HOMICIDE		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 March, 1952 , to 14 March, 1953 , that I last saw the deceased alive on 13 March, 1953 , and that death occurred at 7:15 A.M. , from the causes and on the date stated above.				
23a. SIGNATURE David H. Glenn M.D. (Degree or title)		23b. ADDRESS Warsaw Mo.		23c. DATE SIGNED 14 March
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE MAR 15 1953		24c. NAME OF CEMETERY OR CREMATORY Reversida
24d. LOCATION (City/Town, or county) (State) Warsaw Benton Co. Mo.		25. FUNERAL DIRECTOR'S SIGNATURE John Riser Warsaw ADDRESS		
DATE REC'D BY LOCAL REG. 3/15/53		REGISTRAR'S SIGNATURE Jan. A. Logan		

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

080
1

(Licensed Embalmer's Statement on Reverse Side)

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

John A. Reser

Licensed Embalmer No. 4098

P. O. Address Warsaw

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.