

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH  
318

State File No. **3203**  
Registrar's No. **0290**

FILED FEB 2 - 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. \_\_\_\_\_ PRIMARY REG. DIST. NO. **1003** Registrar's No. **0290**

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Indiana</b> b. COUNTY |   |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Mo.</b>  |  | c. LENGTH OF STAY (in this place)   | d. Is Residence within limits of a city or incorporated town?<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>Missouri Baptist Hospital</b> |  | e. STREET ADDRESS (If rural, give location) <b>81308</b>  |   |

|                                     |                          |                       |                         |   |
|-------------------------------------|--------------------------|-----------------------|-------------------------|---|
| 3. NAME OF DECEASED (Type or Print) | a. (First) <b>Andrew</b> | b. (Middle) <b>J.</b> | c. (Last) <b>Varner</b> | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>Jan. 10, 1955</b> |
|-------------------------------------|--------------------------|-----------------------|-------------------------|---|

|                    |                               |   |  |   |                      |                        |      |
|--------------------|-------------------------------|---|--|---|----------------------|------------------------|------|
| 5. SEX <b>Male</b> | 6. COLOR OR RACE <b>White</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widower</b> | 8. DATE OF BIRTH <b>April 20, 1871</b> | 9. AGE (In years last birthday) <b>83</b> | IF UNDER 1 YEAR Days | IF UNDER 24 HRS. Hours | Min. |
|--------------------|-------------------------------|---|--|---|----------------------|------------------------|------|

|   |  |   |  |
|---|--|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b> | 10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b> | 11. BIRTHPLACE (City and State or Foreign Country) <b>Spencer County, Indiana</b> | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> |
|---|--|---|--|

|                                       |  |  |
|---------------------------------------|--|--|
| 13a. FATHER'S NAME <b>Adam Varner</b> | 13b. MOTHER'S MAIDEN NAME <b>Barbara Kellems</b> | 14. NAME OF HUSBAND OR WIFE <b>Ella Varner</b> |
|---------------------------------------|--|--|

|   |                                     |  |                                 |
|---|-------------------------------------|--|---------------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b> | 16. SOCIAL SECURITY NO. <b>Nil.</b> | 17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. E. B. Turner</b> | ADDRESS <b>4767 Plover Ave.</b> |
|---|-------------------------------------|--|---------------------------------|

|   |   |  |   |
|---|---|--|---|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Chemical Peritonitis</b>  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b> |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <b>acute Hemorrhagic Parvovirus</b> |  |   |
|   | DUE TO (c) <b>old myocardial infarct</b>  |  |   |
| II. OTHER SIGNIFICANT CONDITIONS<br>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?<br>YES <input checked="" type="checkbox"/> NO <input 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)<br><b>4201</b> |
|--|--|--|

|   |  |                            |
|---|--|----------------------------|
| 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 **1-8-55**, 19\_\_\_\_, to **1-10-55**, 19\_\_\_\_, that I last saw the deceased alive on **1-10-55**, 19\_\_\_\_, and that death occurred at **11:57 A.M.**, from the causes and on the date stated above.

|   |                                |                                 |
|---|--------------------------------|---------------------------------|
| 23a. SIGNATURE (Degree or title) <b>James P. Meadows M.D.</b> | 23b. ADDRESS <b>45 Central</b> | 23c. DATE SIGNED <b>1-11-55</b> |
|---|--------------------------------|---------------------------------|

|  |                          |   |  |
|--|--------------------------|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b> | 24b. DATE <b>1-11-55</b> | 24c. NAME OF CEMETERY OR CREMATORY <b>Richardson Cemetery</b> | 24d. LOCATION (City, town, or county) (State) <b>Lincoln City, Indiana</b> |
|--|--------------------------|---|--|

|   |   |  |                                 |
|---|---|--|---------------------------------|
| DATE REC'D BY LOCAL REG. <b>JAN 11 1955</b> | REGISTRAR'S SIGNATURE <b>Charles Smith M.D.</b> | 25. FUNERAL DIRECTOR'S SIGNATURE <b>Fred M. Williams</b> | ADDRESS <b>4700 Washington.</b> |
|---|---|--|---------------------------------|

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..

Student.....  
Signature of Student Embalmer

Signed *E. J. ...*.....

Licensed Embalmer No. *428*

P. O. Address *St. Louis*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.