

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

**25417**

State File No. ....

**FILED AUG 29 1955**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **915**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Buchanan</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission.) a. STATE <b>Kansas</b> b. COUNTY <b>Doniphan</b>			
b. CITY (If outside corporate limits, write RURAL and give town or township) OR TOWN <b>St. Joseph</b>		c. LENGTH OF STAY (in this place) <b>15 Days</b>	c. CITY OR TOWN <b>Troy</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <b>Mo. Methodist Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>815 8</b>			
<b>3. NAME OF DECEASED</b> (Type or Print) a. (First) <b>John</b> b. (Middle) <b>Francis</b> c. (Last) <b>Werner</b>			<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>Aug. 17 1955</b>		
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <b>Widowed</b>	<b>8. DATE OF BIRTH</b> <b>Sept. 30 1879</b>	<b>9. AGE</b> (In years last birthday) <b>75</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Agriculture.</b>	<b>11. BIRTHPLACE</b> (City and State or Foreign Country) <b>Troy Kansas</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>
<b>13a. FATHER'S NAME</b> <b>Paul F. Werner</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Louisa Graves</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Jeanette Werner (deceas)</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No.</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>	<b>17. INFORMANT'S SIGNATURE OR NAME ADDRESS</b> <b>Paul Werner Hiawatha Kans.</b>		
<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		<b>MEDICAL CERTIFICATION</b> <b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <b>Pulmonary embolism</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Myocardial infarction</b> DUE TO (c) <b>Arteriosclerotic heart disease</b>			<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>minutes</b>  <b>approx 4 hrs</b>  <b>unknown</b>
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <b>4200.</b>			<b>20. AUTOPSY?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)		<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b>		
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>21f. HOW DID INJURY OCCUR?</b>		
<b>22. I hereby certify that I attended the deceased from</b> <b>8-2</b> , 19 <b>55</b> , to <b>8-17</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>8-18</b> , 19 <b>55</b> , and that death occurred at <b>9:30</b> a.m., from the causes and on the date stated above.					
<b>23a. SIGNATURE</b> (Degree or title) <b>William H. Ames, M.D.</b>			<b>23b. ADDRESS</b> <b>902 Edmund St. St. Joseph, Mo.</b>		<b>23c. DATE SIGNED</b> <b>8-22-55</b>
<b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Removal</b>		<b>24b. DATE</b> <b>8/17/55</b>	<b>24c. NAME OF CEMETERY OR CREMATORY</b> <b>Mt. Olive</b>		<b>24d. LOCATION</b> (City, town, or county) (State) <b>Troy Kansas</b>
<b>DATE REC'D BY LOCAL REG.</b> <b>Aug 25, 1955</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Robert M. Allison</b>		<b>25 FUNERAL DIRECTOR'S SIGNATURE ADDRESS</b> <b>Vernon B. Tibbitts Troy Kans.</b>	

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

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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 *Charles M. Hasme*

Licensed Embalmer No. *448*

P. O. Address *Watkins*

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.