

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

8194

State File No. ....

380

FILED APR 9 - 1956

42

PRIMARY REG. DIST. NO. 1000

Registrar's No. ....

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

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Andrew</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Joseph</b>	c. LENGTH OF STAY (In this place) <b>1mo-13days</b>	c. CITY OR TOWN <b>Savannah</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>State Hospital #2</b>		e. STREET ADDRESS (If rural, give location) <b>00231</b>	

3. NAME OF DECEASED (Type or Print) <b>ROY</b>	a. (First)	b. (Middle)	c. (Last) <b>WARNER</b>	4. DATE OF DEATH <b>April 4, 1956</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Oct. 9, 1890</b>	9. AGE (In years last birthday) <b>65</b>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 2 HRS. Hours	IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>Andrew County, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Con Warner</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Unknown</b>
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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>499-07-5383</b>	17. INFORMANT'S SIGNATURE OR NAME <b>John Warner, Maxwell Rd., St. Joseph, Mo.</b>	ADDRESS
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Decompensated Heart</b>		<b>Chronic</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Pulmonary cavitation bilateral</b> DUE TO (c) <b>Psychotic</b>		<b>Chronic</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<b>2 months</b>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from April 4, 1956, to April 4, 1956, that I last saw the deceased alive on April 3, 1956, and that death occurred at 12:20A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>C. E. Gossain M.D.</b>	23b. ADDRESS <b>Mo. State Hospital #2, St. Joseph,</b>	23c. DATE SIGNED <b>Apr 4, 1956</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>4-6-1956</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Bethel</b>	24d. LOCATION (City, town, or county) (State) <b>near Cosby mo</b>
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DATE REC'D BY LOCAL REG. <b>Apr 4, 1956</b>	REGISTRAR'S SIGNATURE <b>Ethel M. Allison</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Breit Funeral Home Savannah mo</b>	ADDRESS
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(Licensed Embalmer's Statement on Reverse Side)

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

65-0

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. C. Breit* .....

Licensed Embalmer No. *265*

P. O. Address *Savannah*

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.