. Health,
& Welfare
. Public
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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-032213
STATE FILE NUMBER

FILED OCT 15 1958 Registration District No. 99 Primary Registration District No. 4168 Registrar's No. 63

1. PLACE OF DEATH
a. COUNTY: DeKalb
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Maysville — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION — Length of stay in 1b: 25 Yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: DeKalb
c. CITY OR TOWN: Maysville 0320 — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) — Reside on Farm: Yes [ ] No [ ]

3. NAME OF DECEASED (Type or print): First CLARA Middle ERNESTINE Last WARNER
4. DATE OF DEATH: Month Sept Day 28 Year 1958

5. SEX: Female 1
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] .2 DIVORCED [ ]
8. DATE OF BIRTH: Mar.10 1875
9. AGE (In years last birthday): 83 — IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Chicago Illinois 1
12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME: Fred Brauch
13b. MOTHER'S MAIDEN NAME: Ernestine Shoenberger
14. NAME OF HUSBAND OR WIFE: Walter Warner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs.Martha Goodwin, Address: Maysville Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Endocarditis — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b):
DUE TO (c): 4214
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ] 0

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION — COUNTY — STATE

21. I attended the deceased from April 45, to 9/28/58 and last saw her/him alive on 9/28/58
Death occurred at 9:10 A.m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Harold Fowler DC
22b. ADDRESS: Maysville Mo
22c. DATE SIGNED: 9/30-58

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 9-30-58
23c. NAME OF CEMETERY OR CREMATORY: Mt.Plesant
23d. LOCATION (City, town, or county) (State): Maysville Mo. (Rural)

24. FUNERAL DIRECTOR — ADDRESS: Pilcher Funeral Home, Maysville Mo
25. DATE RECD. BY LOCAL REG.: 10-4-58
26. REGISTRAR'S SIGNATURE: Lasure Davidson

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
All diseases in Part I must be causally related.

NOV 13 1958

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 .....
C.D.Pilcher

Licensed Embalmer No....3960.....

P. O. Address Maysville 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.