

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-037335

STATE FILE NUMBER

402
403

FILED OCT 27 1958

Registration District No. 274

Primary Registration District No. 3052

Registrar's No. 403

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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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Pettis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pettis</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sedalia</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Sedalia</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bothwell Hospital</u>			Length of stay in 1b		080% STREET ADDRESS <u>906 So. Kentucky</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last <u>CARL Phillip WERNER</u>				4. DATE OF DEATH Month Day Year <u>Oct. 20 1958</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 29 1879</u>		9. AGE (In years last birthday) <u>79</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>1 21</u>		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Plumbing</u>		11. BIRTH PLACE (City and state or country) <u>Sedalia Mo</u>			12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>					
13a. FATHER'S NAME <u>Phillip Warner</u>				13b. MOTHER'S MAIDEN NAME <u>Dora Walchner</u>				14. NAME OF HUSBAND OR WIFE <u>Wallace Mays Warner</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no no</u>				16. SOCIAL SECURITY NO. <u>496-16-4890</u>		17. INFORMANT Address <u>Mrs. Louise Mitealf Sedalia</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Coronary insufficiency.</u> DUE TO (c) <u>4201</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>			
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY-OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)										
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										
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 <u>10-19-58</u> to <u>10-20-58</u> and last saw ^{her} alive on <u>10-20-58</u> Death occurred at <u>1:35 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>Chas Gordon Hanfjacha used</u> (Degree or title)						22b. ADDRESS <u>Sedalia Mo</u>			22c. DATE SIGNED <u>10-20-58</u>				
23a. BURIAL CREMATION <u>Burial</u>		23b. DATE <u>10-22-1958</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Hill cem.</u>			23d. LOCATION (City, town, or county) (State) <u>Warsawburg Mo</u>						
24. FUNERAL DIRECTOR <u>M^cLaughlin Bros</u> ADDRESS <u>Sedalia</u>				25. DATE RECD. BY LOCAL REG. <u>October 21, 1958</u>		26. REGISTRAR'S SIGNATURE <u>Frances Kelby</u>							

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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 *Philip M. McLaughlin*

Licensed Embalmer No. *3729*

P. O. Address *Scaloria*

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.