

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-039718

FILED VS DEC 7 1959

STATE FILE NUMBER

Registration District No. 28 Primary Registration District No. 2000 Registrar's No. 1301

INDEXED

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield	Length of stay in 1b	c. CITY OR TOWN Springfield	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 650 S. Nettleton		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 650 S. Nettleton

3. NAME OF DECEASED (Type or print) First WALTER Middle H. Last WARNICK			4. DATE OF DEATH Month November Day 30 , Year 1959		
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5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6 April 1896	9. AGE (last birthday) 63	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Employee	10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (City and state or country) Richardson, Kentucky	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Hiram Warnick	13b. MOTHER'S MAIDEN NAME Alice Neil	14. NAME OF HUSBAND OR WIFE Lenore Warnick
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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) Yes WWI	16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT Address Lenore Warnick (Wife) Springfield, Mo.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH 20 Min.
IMMEDIATE CAUSE (a) Cerebral Vascular accident		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) arteriosclerotic vascular disease	
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Coronary insufficiency	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <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 Springfield, Missouri	COUNTY Greene	STATE Missouri
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21. I attended the deceased from Apr 4 1957 to 11/30/59 and last saw ^{him} her alive on Aug 28 '59 Death occurred at 8:00 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>[Signature]</i> (Degree or title)	22b. ADDRESS 609 Chery Springfield, Missouri	22c. DATE SIGNED Dec 1 '59 (State)
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12/2/59	23c. NAME OF CEMETERY OR CREMATORY Local	23d. LOCATION (City, town, or county) Ashland, Kentucky
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24. FUNERAL DIRECTOR ADDRESS KLINGNER MORTUARY, INC. SPRINGFIELD MO.	25. DATE RECD. BY LOCAL REG. 12-3-59	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS DEC 2 1959

MAR 16 1961

DEC 10 1959

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 Catherine King
Licensed Embalmer No. 3719

P. O. Address _____

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.