

# IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**=60-000884**

FILED VS. JAN 19 1960 100

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **3**

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>DENT</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>DENT</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>OSAGE TOWNSHIP</b>		c. CITY OR TOWN <b>OSAGE TOWNSHIP</b>	
Length of stay in 1b <b>14 YRS</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>RESIDENCE 4 mi NO. HONES MILL MO.</b>		d. STREET ADDRESS (If outside, give location) <b>P.O., BOSS, MO</b>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>BENJAMIN</b> Middle <b>FRANKLIN</b> Last <b>WARFEL</b>			4. DATE OF DEATH Month <b>JAN.</b> Day <b>17</b> Year <b>1960</b>		
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2/22/1875</b>	9. AGE (last birthday) <b>84</b>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER (RET.)</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>AGRICULTURE</b>	11. BIRTHPLACE (City and state or country) <b>DENT COUNTY, MO.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>THOMAS E. WARFEL</b>	13b. MOTHER'S MAIDEN NAME <b>NANCY JANE HOPKINS</b>	14. NAME OF HUSBAND OR WIFE <b>AMANDA (DECD)</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>NONE</b>	17. INFORMANT <b>Cynthia Feibelman</b> Address <b>BOSS, MO.</b>
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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: IMMEDIATE CAUSE (a) <b>1. Arteriosclerotic heart disease</b> <b>2. Carcinoma of tongue with met-astases</b> DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____		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

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	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 COUNTY _____ STATE _____
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21. I attended the deceased from **1/28/50** to **1/7/60** and last saw <sup>her</sup>him alive on **1/7/60**  
Death occurred at **8:00 A.M.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Alice S. Crowley M.D.</b> (Degree or title)	22b. ADDRESS <b>Salem Missouri</b>	22c. DATE SIGNED <b>1/18/60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>JAN. 19, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>STONE HILL CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>DENT COUNTY MO</b>
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24. FUNERAL DIRECTOR <b>Max L. Warfel</b> ADDRESS <b>Salem, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>1/18/60</b>	26. REGISTRAR'S SIGNATURE <b>M.M. Hart, M.D. by A.M.</b>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed May L. Waite

Licensed Embalmer No. 4170

P. O. Address Salem, N.

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.