

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-035283

STATE FILE NUMBER

Registration District No. 164 Primary Registration District No. 3032 Registrar's No. 130

DO NOT WRITE ON THIS STUB

AMENDED

FILED SEP 17 1962

1. PLACE OF DEATH a. COUNTY <u>Johnson</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Warrensburg</u> Length of stay in lb <u>2 Days</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Ross Nursing Home</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Johnson</u> c. CITY OR TOWN <u>Montserrat</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>None</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>WARNER</u> Last 4. DATE OF DEATH <u>September 12, 1962</u>
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5. SEX <u>Female</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>12/20/1876</u>	9. AGE (last birthday) <u>87</u>	IF UNDER 1 YEAR Months _____ Days _____	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) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Gallatin, Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>George Cornelius</u>	13b. MOTHER'S MAIDEN NAME <u>Margaret Eckleberry</u>	14. NAME OF HUSBAND OR WIFE <u>Samuel E. Warner</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT Address <u>Marjorie Hunter, Warrensburg, Missouri</u>
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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) <u>Bronchopneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Acute Gastrointestinal upset</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Generalized Atherosclerosis</u>	INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>4 days</u>
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 checked="" 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 <u>9-10-62</u> to <u>9-12-62</u> and last saw her <u>him</u> alive on <u>9-10-62</u> Death occurred at <u>6:00 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>R. Lee Cooper</u> (Degree or title) <u>M.D.</u>	22b. ADDRESS <u>Warrensburg, Missouri</u>	22c. DATE SIGNED <u>9/13/1962</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9/15/1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>KnobNoster Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>KnobNoster, Missouri</u>
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24. FUNERAL DIRECTOR ADDRESS <u>The Brauningers, Warrensburg, Missouri</u>	25. DATE RECD. BY LOCAL REG. <u>Sept. 14, 1962</u>	26. REGISTRAR'S SIGNATURE <u>Savannah Crutchfield</u>
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VS 300 Rev. 4/59
10515
20510
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4 1
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9544.2
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1286-0
131-0

DATE AMENDED
2
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
SHOULD READ
ITEM NO.
BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

SEP 19 1962

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 Stephen E. Johnson

Licensed Embalmer No. 5191

P. O. Address Warrensburg, 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.