

1939 DEC 18 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

40350
Do not use this space.

1. PLACE OF DEATH

(a) County Waynes Registration District No. 55
(b) Township Lawson Primary Registration District No. 6262 Registered No. 1397
(c) City Hartzell (d) Street No. _____ St.
(If death occurred in Hospital, or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
Belarance Warner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF single
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 13 / 39
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. _____ min.
Steuborn baby
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Hartzell Mo
13. NAME Wesley Warner
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo
15. MAIDEN NAME Inda Belle Hunt
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo
17. INFORMANT (ADDRESS) Wesley Warner Hartzell Mo
18. BURIAL, CREMATION, OR REMOVAL PLACE Lawson DATE Nov 13 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Bob Finney
20. FILED Dec 8 1939 M. V. Munn Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 13 1939
22. I HEREBY CERTIFY, That I attended deceased from Nov 13 1939 to Nov 13 1939
I last saw him alive on Nov 13 1939. Death is said to have occurred on the date stated above, at 6:45 p.m.
The principal cause of death and related causes of importance were as follows:
Premature infant about 6 mo. duration
Date of onset _____
Other contributory causes of importance: None
Name of operation None Date of _____
What test confirmed diagnosis? Chadwick Was there an autopsy? No
23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? No Date of injury _____, 19____
Where did injury occur? None (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury None
Nature of injury None
24. Was disease or injury in any way related to occupation of deceased?
If so, specify _____ (Signed) B. E. Cecil M. D.
Edison Mo (Address)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED

District Health Officer No. 2

District File Number 1239-450

Date Filed 12-18

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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 this body is not embalmed, above space should be left blank.