

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

APR 23 1940

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

11143  
Do not use this space.

1. PLACE OF DEATH

(a) County Newport Registration District No. 384

(b) Township West Plains Primary Registration District No. 5227

(c) City West Plains (d) Street No. 1 Registered No. \_\_\_\_\_ St. \_\_\_\_\_

(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 William Warner

(a) Residence, No. \_\_\_\_\_ St.  (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED m (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Daisy Warner

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov-27-1893

7. AGE YEARS 63 MONTHS 4 DAYS 3 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired

9. Industry or business in which work was done, as saw mill, bank, etc. Hotel Clerk

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) Bellevue, Mo

FATHER

13. NAME Christian Warner

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ark

MOTHER

15. MAIDEN NAME Emma A.

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ark

17. INFORMANT Clayton Warner (ADDRESS) West Plains Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Oak Lawn DATE 4-1- 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Robert M. West Plains, Mo

20. FILED 4-1- 1940 Vida W. SIMONS Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3/30- 1940

22. I HEREBY CERTIFY, That I attended deceased from Feb 1939 to March 30, 1940.

I last saw him alive on 3-27- 1940 Death is said to have occurred on the date stated above, at 1:14 p.

The principal cause of death and related causes of importance were as follows:

Chronic Hypertensive Myocarditis Date of onset 1933

Cerebral Thrombosis 1934

Right Hemiplegia 1933

Other contributory causes of importance: Arteriosclerosis

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? Exam Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19 \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify \_\_\_\_\_

(Signed) E. Claude Bohrer, M. D.

(Address) West Plains, Mo

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

*Ralph A. Roberts*

Licensed Embalmer No. *3485*

P. O. Address *West Plains, T*

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 11143

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 384

Primary Registration District No. 4227

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Howell  
(b) City or town West Plains  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME Wm Warner

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 63 Months 4 Days 3 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

(a) H-1-40 (b) Vida W SIMONS  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howell  
(c) City or town West Plains  
(If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month 3 day 30  
year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;

and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature E. Claude Bahers (M. D. or other)

Address West Plains Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

1940

S-11143