

2-40
-39
K23153

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

32197

State File No.

Registration District No. 398

Primary Registration District No. 3019

Registrar's No. 2462

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Independence
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
1406 W. Alton
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Rose Warneson

3. (b) If veteran, name war none 3. (c) Social Security No. none

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

6. (b) Name of husband or wife Charles H. Warneson 6. (c) Age of husband or wife if 75 years

7. Birth date of deceased Nov. 2 - 1868
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>71</u>	<u>11</u>	<u>9</u>	hr. min.

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

10. Usual occupation House wife

11. Industry or business 6

12. Name Peter Fuhrmann

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

14. Maiden name Matilda F. Vogalder

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

16. (a) Informant Charles H. Warneson

(b) Address 1406 W. Alton

17. (a) Burial (b) Date thereof 10/5/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill Cem.

18. (a) Signature of funeral director Geo. E. Carson

(b) Address Independence Mo.

19. (a) Oct. 5 40 (b) F. R. Cook
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Independence
(If outside city or town limits, write "RURAL")

(d) Street No. 1406 West Alton
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 2
year 1940 hour 10 minute A. M.

21. I hereby certify that I attended the deceased from Jan 40 to Oct 2 1940
that I last saw her alive on Sept 10 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Artery Occlusion 10 min
Artery Sclerosis 1 year

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 94 1/2

Major findings: Of operations _____

Of autopsy _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? 2 (a)

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

23. Signature J. H. Hony (M. D. or other) MD
Address Independence Mo Date signed 10-3-40

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

MOTHER FATHER

Dr. Combs

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 *L. M. Deir*

Licensed Embalmer No. *3156*

P. O. Address *Independence*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.