

17-39
X23159

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 199 Primary Registration District No. 4499 Registrar's No. 5

1. PLACE OF DEATH: **Saline Slater**

(a) County **Saline**

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

(c) Name of hospital or institution: **none**

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **all his life** (Specify whether in this community _____ years, months or days)

3. (a) PRINT FULL NAME **Lorenzo Clay Warner**

3. (b) If veteran, name war **no**

3. (c) Social Security No. **none**

4. Sex **male**

5. Color or race **White**

6. (a) Single, widowed, married, divorced, **widowed**

6. (b) Name of husband or wife **none**

6. (c) Age of husband or wife if alive **no**

7. Birth date of deceased **Aug. 25 1858**

(Month) (Day) (Year)

8. AGE: Years **82** Months **4** Days **27**

If less than one day hr. _____ min. _____

9. Birthplace **Iowa Point, Kansas**

(City, county or town) (State or foreign country)

10. Usual occupation **grocery merchant**

11. Industry or business _____

MOTHER FATHER { 12. Name **Phillip Warner**

13. Birthplace **Ohio**

(City, county or town) (State or foreign country)

14. Maiden name **Loretta Twinn**

15. Birthplace **Saline Co. Mo.**

(City, county or town) (State or foreign country)

16. (a) Informant **Mr. C. A. Warner, Slater, Mo.**

(b) Address **burial**

17. (a) _____ (b) Date thereof **1-24-41**

(Burial, cremation, or other disposal) (Month) (Day) (Year)

(c) Place: burial or cremation **Hill Brothers, Slater, Mo.**

18. (a) Signature of funeral director **W. M. Tuttle**

(b) Address _____

19. (a) **1-24** (b) _____ (Registrar's signature)

(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Saline**

(c) City or town **Slater** (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.? **1** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan.** day **22nd** year **1941** hour **5** minute _____ P. M.

21. I hereby certify that I attended the deceased from **Oct 1940** to **Jan - 22 - 1941**, 19____ and that death occurred on the date and hour stated above.

Immediate cause of death **Sclerosis of Brain**

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? **no**

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature **M. C. Duggins** (M. D. or other) _____

Address **Slater Mo** Date signed **1-28-41**

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

878

1000

RECEIVED
District Health Officer No. 0
District File Number 9-13-41
Date Filed

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 4469

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 799

Primary Registration District No. 4479

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Saline

(b) City or town Stater
(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 _____ years, months or days)

3. (a) PRINT FULL NAME Lorenzo Clay 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 wid

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 Months Days If less than one day

82	4	27	hr. min.
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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 _____

19. (a) _____ (b) _____ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (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.

20. DATE OF DEATH: Month Jan day 22 year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: Deterioration of Brain
Due to Cerebro-Spinal Sclerosis.

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 M. E. Suggins (M. D. or other) _____
Address Seaton, Mo. Date signed 4/12/47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

