S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6793

FILED FEB 16 1945

Registration District No. 237 Primary Registration District No. 3048 Registrar's No. 16

1. PLACE OF DEATH:
(a) County Nodaway
(b) City or town Maryville (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Francis Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days (Specify whether years, months or days)
In this community 48 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Andrew
(c) City or town Savannah (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Opal Marie Warner
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife Roy Warner
6. (c) Age of husband or wife if alive 54 years
7. Birth date of deceased Aug (Month) 3 (Day) 1896 (Year)
8. AGE: Years 48 Months 6 Days 21 If less than one day hr. min.
9. Birthplace Andrew Co (City, town, or county) Mo (State or foreign country)
10. Usual occupation At Home
11. Industry or business
12. Name J. H. Graves (Father)
13. Birthplace Holt County (City, town, or county) Mo (State or foreign country)
14. Maiden name Maude Fuller (Mother)
15. Birthplace Andrew Co (City, town, or county) Mo (State or foreign country)
16. (a) Informant Roy Warner
(b) Address Savannah Mo
17. (a) (Burial, cremation, or removal) (b) Date thereof 1-26-45 (Month) (Day) (Year)
(c) Place: burial or cremation Savannah
18. (c) Signature of funeral director E. C. Breit
(b) Address Savannah
19. (a) Jan. 25-45 (Date received local registrar) (b) Amy Barber (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 24 year 1945 hour 8 minute 55 A.M.
21. I hereby certify that I attended the deceased from 1-21, 1945, to 1-24, 1945, that I last saw her alive on 1-24, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death: Tuberculosis of both lungs Chr Myocarditis

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature J. M. Boyle (M. D. or other)
Address Maryville Mo Date signed 1-26-45

1384

(Licensed Embalmer's Statement on Reverse Side)

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.