

S. No. 2
8-43
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19584

State File No. _____

Registrar's No. 675

FILED JUN 12 1946

Registration District No. 42

Primary Registration District No. 1000

1. PLACE OF DEATH:

(a) County Buchanan

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

(c) Name of hospital or institution: General Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 hr. 15 min.
(Specify whether _____)

In this community 7 hr. 15 min.
years, months or days

2. USUAL RESIDENCE OF DECEASED: ANDREW

(a) State Mo. (b) County Buchanan

(c) City or town St. Joseph SAVANNAH
(If outside city or town limits, write "RURAL")

(d) Street No. General Hospital
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME JUDY ANN WARNER

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 7
year 1946 hour 4 minute 30 p. M.

21. I hereby certify that I attended the deceased from 9:50 am
6/7 1946 to 4:30 pm 6/7 1946;
that I last saw her alive on 6/7/46 19
and that death occurred on the date and hour stated above.

4. Sex female 5. Color or race White

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

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: June 1946
(Month) (Day) (Year)

Immediate cause of death: Atelectasis

Duration: 7 hr

8. AGE:	Years	Months	Days	If less than one day
	<u>0</u>	<u>0</u>	<u>0</u>	<u>7 hr. 15 min.</u>

Due to _____

Due to _____

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

Other conditions (include pregnancy within 3 months of death) _____

Major findings: _____

Of operations _____

Of autopsy _____

10. Usual occupation none

11. Industry or business _____

12. Name Cecil L. Warner

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

14. Maiden name Delores Ann Allen

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

PHYSICIAN

Underline the cause to which death should be charged statistically.

None

16. (a) Informant Cecil L. Warner

(b) Address Savannah, Mo.

17. (a) 13 (b) Date thereof 6-8-46
(Burial, cremation, or removal) (Month) (Day) (Year)

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? _____

(c) Place: burial or cremation Savannah

18. (a) Signature of funeral director E. C. Braith.

(b) Address Savannah

19. (a) June 11-1946 (b) A. H. Hildebrand
(Date received local registrar) (Registrar's signature)

(Specify type of place) _____

While at work? _____ (c) Means of injury _____

23. Signature Clifford L. Hildebrand M. D. or other _____

Address Savannah Mo. Date signed 6/8/46

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

18460

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..... *E. C. Breit*.....

Licensed Embalmer No. *2650*.....

P. O. Address *Savannah Ga*.....

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.