

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33306

State File No.

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 821

1. PLACE OF DEATH:

(a) County GREENE
(b) City or town SPRINGFIELD
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1219 N. DOUGLAS
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.
In this community 57 years, months or days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County BARTON
(c) City or town LAMAR
(If outside city or town limits, write "RURAL")
(d) Street No. 200 E 11th St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME WILLIAM GOODWIN WARNER

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

4. Sex MALE 5. Color or race WH 6. (a) Single, widowed, married, divorced, MARRIED

6. (b) Name of husband or wife MARY RUTH WARNER 6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased JAN 22 1970 (Month) (Day) (Year)

8. AGE: Years 76 Months 8 Days 18 If less than one day hr. min.

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

10. Usual occupation RETIRED

11. Industry or business POST OFFICE

12. Name ASA P. WARNER

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

14. Maiden name ELIZA GOULD (State or foreign country)

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

16. (a) Informant WM WARNER, JR

(b) Address 1219 N. DOUGLAS SPRINGFIELD

17. (a) BURIAL (b) Date thereof OCT. 13 '46 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation LAKE CEME

18. (a) Signature of funeral director GIBSON FUNERAL HOME

(b) Address LAMAR, MO

19. (a) 10-11-46 (b) H. S. Handley M.D. (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCTOBER day 10 year 1946 hour 1 minute 26 P.M.

21. I hereby certify that I attended the deceased from 10-8-1946 to 10-10-1946 that I last saw him alive on 10-10-1946 and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of Glomerular System

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) (c) Means of injury

23. Signature W. Kelly (M. D.) Address Springfield, Mo Date signed 10-10-46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

111

MAR 16 1954

OCT 28 1950

NOV 26 1946

SEP 22 1947

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 *Ch. Gibson*

Licensed Embalmer No. 4137

P. O. Address Lamar, Mo.

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.

X