

S. No. 2
M-5-43
v. 5-17-39
I X36671

FILED JUL 14 1947

Registration District No. **164** Primary Registration District No. **3032**

1. PLACE OF DEATH:

(a) County **Johnson**

(b) City or town **Warrensburg Mo.**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Warrensburg Hospital & Clinic Inc.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **14 Days**
(Specify whether years, months or days)

In this community **10 Yrs**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Johnson** **51**

(c) City or town **Warrensburg** **3**
(If outside city or town limits, write "RURAL")

(d) Street No. **425 E Gay St** **2**
(If rural, give location)

(e) Citizen of foreign country? **no** (Yes or No)

If yes, name country.....

3. (a) PRINT FULL NAME **Samuel Wackiff**

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

3. (c) Social Security No. **no**

4. Sex **Male** 5. Color or race **White**

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

6. (b) Name of husband or wife **Susie Mae Wackiff**

6. (c) Age of husband or wife if alive **Deceased**

7. Birth date of deceased **March 18, 1869**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **2**
year **1947** hour **11** minute **K.P.M.**

21. I hereby certify that I attended the deceased from **June 17** to **July 2, 1947**
that I last saw him alive on **July 2, 1947**
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
78	78	3	14	hr. min.

Immediate cause of death
Sept Cerebral Hemorrhage 24hrs

Due to **Myocardial Infarction**
Coronary Artery Disease **7 yr**

Due to.....

Other conditions
(Include pregnancy within 3 months of death)

9. Birthplace **N.Y.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired Farmer**

11. Industry or business.....

MOTHER, FATHER {

12. Name **Not known** **9**

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

14. Maiden name **not known** **Not known**

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

PHYSICIAN

Major findings:
Of operations..... **MI**

Of autopsy.....

Underline the cause to which death should be charged statistically.

16. (a) Informant **Mason Wackiff**

(b) Address **Warrensburg Mo**

17. (a) **Burial** (b) Date thereof **July 3 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Sunset Hill**

18. (a) Signature of funeral director **Sweeney Phillips**

(b) Address **Warrensburg Mo.**

19. (a) **7-5-47** (b) **Sarah Ann Phillips**
(Date received local registrar) (Registrar's signature)

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 **0**

23. Signature **[Signature]** (M. D. or other)

Address **Warrensburg Mo.** Date signed **7/4/47**

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

JUL 21 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..... *P. Q. Phillips.*

Licensed Embalmer No. *2320*

P. O. Address. *Warrensburg, 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.