

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-036215

STATE FILE NUMBER

FILED NOV 3 1958 Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 73

S. 300
1-57
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1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>West Plains</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>West Plains</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Christa Hagen</u>		Length of stay in lb <u>WKS</u>	d. STREET ADDRESS (If outside, give location) <u>046 Rte 2</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>Marion Franklin Janner</u>			4. DATE OF DEATH Month Day Year <u>10-15-1958</u>		
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5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/19-1868</u>	9. AGE (In years last birthday) <u>89</u>	10. FUNDER 1 YEAR Months Days <u>9 24</u>	11. IF UNDER 24 HRS. Hours Min. <u>24</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>	11. BIRTHPLACE (City and state or country) <u>Danvers, Ky</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>M.A. Janner</u>	13b. MOTHER'S MAIDEN NAME <u>Cerilda Lovelace</u>	14. NAME OF HUSBAND OR WIFE <u>But Janner, West Plains Mo</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Spanish American</u>	16. SOCIAL SECURITY NO. <u>332X</u>	17. INFORMANT <u>But Janner, West Plains Mo</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arteriosclerosis</u>		<u>9 years</u>
	DUE TO (c) <u>332X</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from 12/18/49 to 10/15/58 and last saw ~~xx~~ him alive on 10/15/58
Death occurred at 10:45 P on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Death or title) <u>E. Callahan M.D.</u>	22b. ADDRESS <u>West Plains, Missouri</u>	22c. DATE SIGNED
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>10/17-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Hope</u>	23d. LOCATION (City, town, or county) (State) <u>Kearney Valley Mo</u>
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24. FUNERAL DIRECTOR <u>Robertson West Plains</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>10-29-58</u>	26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 MEDICAL CERTIFICATION
 All diseases in Part I must be causally related.

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, Student Embalmer No. working under my personal supervision.

Student

Signature of Student Embalmer

Signed

A. A. Roberts

Licensed Embalmer No. *3430*

P. O. Address *West Fla*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.