

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-001912  
STATE FILE NUMBER

FILED JAN 27 1959

Registration District No. 170 Primary Registration District No. 3033 Registrar's No. 9

300  
-57

1. PLACE OF DEATH a. COUNTY <u>LACLEDE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>LACLEDE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>LEBANON</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>LEBANON</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>503 CHESNUT ST</u>		Length of stay in lb <u>14 YRS.</u>	d. STREET ADDRESS (If outside, give location) <u>503 CHESNUT</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>William Samuel Warrington</u>			4. DATE OF DEATH Month Day Year <u>1-22-1959</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/1/1874</u>	9. AGE (In years last birthday) <u>85</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>1</u>
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 <u>FARMING</u>	11. BIRTHPLACE (City and state or country) <u>LATHROP, MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>THOMAS WARRINGTON</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>EDITH WARRINGTON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>---</u>	17. INFORMANT Address <u>MRS. FRED BRANDT Lebanon, Mo.</u>		

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>Cerebro-vascular accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>331X</u>		

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.) <u>331X</u>	
20c. TIME OF INJURY Hour _____ 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

21. I attended the deceased from Death occurred at <u>Jan. 18, 1959</u> to <u>Jan. 22, 1959</u> and last saw him alive on <u>Jan. 20, 1959</u> at <u>2:04 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Denote or title) <u>W. Warrington M.D.</u>	22b. ADDRESS <u>119 N. JEFFERSON, Lebanon, Mo</u>	22c. DATE SIGNED <u>1-24-59</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>1-25-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. ROSE</u>	23d. LOCATION (City, town, or county) (State) <u>LEBANON MO</u>
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24. FUNERAL DIRECTOR <u>of Sherr</u>	ADDRESS <u>LEBANON, MO</u>	25. DATE RECD. BY LOCAL REG. <u>1-24-1959</u>	26. REGISTRAR'S SIGNATURE <u>Hella L. May</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

Date Filed JAN 26 1938

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 *R. L. Barber*

Licensed Embalmer No. *3848*  
P. O. Address *Mt. Law Mt.*

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.