

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-012888

STATE FILE NUMBER

FILED MAY 15 1959

Registration District No. 111 Primary Registration District No. 5426 Registrar's No. 17

300  
1-57

1. PLACE OF DEATH a. COUNTY <i>Franklin</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Franklin</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Boles Township</i>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <i>Labadie</i> 0360 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Labadie, Mo.</i>		Length of stay in lb <i>5 yrs.</i>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <i>Adolph C. Warner</i>			4. DATE OF DEATH Month Day Year <i>May 9, 1959</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 14 1900</i>
9. AGE (In years less birthday) <i>58</i>		10. UNDER 1 YEAR Months Days <i>10 25</i>	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cob Pipe Worker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Cob Pipe Factory</i>	11. BIRTHPLACE (City and state or country) <i>Bluffton, Missouri, U. S. A.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13a. FATHER'S NAME <i>Nick Warner</i>	13b. MOTHER'S MAIDEN NAME <i>Sophie Lautenschlager</i>
14. NAME OF HUSBAND OR WIFE <i>Ernie L. Warner</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give year of dates of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>500-10-8842</i>
17. INFORMANT <i>Mr. Ernie L. Warner</i>		Address <i>Labadie, Mo.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Crush injury of chest -</i>			INTERVAL BETWEEN ONSET AND DEATH <i>Instant</i>
DUE TO (b) <i>Accident was pinned</i>			91 2.1 3
DUE TO (c) <i>Beneath tractor wheel</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Intoxicated when he was operating</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" 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.) <i>Same - attempting to start</i>		
20c. TIME OF INJURY Hour Month, Day, Year <i>3:30 p.m. 6/9/59</i>	20d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, factory, street, office bldg., etc.) <i>Farm - Spauld Co Labadie</i>	20f. CITY, TOWN, OR LOCATION <i>Franklin</i>	COUNTY <i>Franklin</i>	STATE <i>Mo.</i>
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at <i>3:30 P</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Dr. J. H. ...</i>		22b. ADDRESS <i>...</i>	22c. DATE SIGNED <i>5/10/59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>May 12, 1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Rhineland Co. Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Rhineland, Missouri</i>
24. FUNERAL DIRECTOR <i>Hieburg &amp; Witt, Inc.</i>		25. DATE RECD. BY LOCAL REG. <i>May 12 - 1959</i>	26. REGISTRAR'S SIGNATURE <i>Mary B. Erwin</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc.: must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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MAY 21 1958

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 *Lester A Witt* .....

Licensed Embalmer No. *3254* .....  
P. O. Address. *Washington, D.C.*

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.