

**DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**FILED VS AUG 4 1959 8**

**59-024917**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. 29

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Hickory</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Hickory</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Preston</u>	Length of stay in 1b <u>43 years</u>	c. CITY OR TOWN <u>Preston</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>So. Preston</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>South Preston</u>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Reed</u> Middle <u>A.</u> Last <u>Warner</u>			4. DATE OF DEATH Month <u>July</u> Day <u>31</u> Year <u>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>2-5-1888</u>	9. AGE (last birthday) <u>71</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months <u>5</u> Days <u>26</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Oil Service Station</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Service Station</u>	11. BIRTHPLACE (City and state or country) <u>Fronton Ohio</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Samuel Warner</u>		13b. MOTHER'S MAIDEN NAME <u>Rebelle Nepture</u>		14. NAME OF HUSBAND OR WIFE <u>Alto Warner</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WWII</u>		16. SOCIAL SECURITY NO. <u>500-36-5246</u>	17. INFORMANT <u>Alto Warner - Preston, Mo</u>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<u>Myocardial Failure</u>	<u>10 yrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Heart Block</u>	
	DUE TO (c) <u>Myocardial Weakness</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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 _____ a.m. _____ p.m.	Month, Day, Year _____	
20d. INJURY OCCURRED WHILE AT WORK <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 \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_.  
Death occurred at 11:45 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>H. R. Easton M.D.</u>	22b. ADDRESS <u>Hickory County, Heaubleau, Mo</u>	22c. DATE SIGNED <u>July 31, 59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Aug 3-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bowers Chapel</u>
24. FUNERAL DIRECTOR <u>Ed West Anthony</u>		23d. LOCATION (City, town, or county) (State) <u>Hickory, Mo</u>
ADDRESS <u>Whithead, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Aug 1-1959</u>
		26. REGISTRAR'S SIGNATURE <u>May Johnson</u>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 13 1955

AUG 13 1959

JAN 26 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Chas. Gilbert Hathaway

Licensed Embalmer No. 4267

P. O. Address Yuba County

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.