

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 28 1959

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STATE FILE NUMBER

Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 199

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Saline</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Saline</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marshall</u>	Length of stay in lb <u>3 months</u>	c. CITY OR TOWN <u>Grand Pass</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>Fitzgibbon Hosp</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>5 1/2 NW Grand Pass</u>
Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>OREN</u> Middle <u>OLIVER</u> Last <u>WARNER</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>22</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>12-31-1901</u>	9. AGE (last birthday) <u>57</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </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>Gen. Farming</u>	11. BIRTHPLACE (City and state or country) <u>Dallas County, Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>George Warner</u>		13b. MOTHER'S MAIDEN NAME <u>Lillie Cheek</u>		14. NAME OF HUSBAND OR WIFE <u>Ada Warner</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>500-03-3240</u>	17. INFORMANT <u>Mrs. Ada Warner</u>	Address <u>Malta Bend R 2</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>Carcinoma of Colon.</u>		INTERVAL BETWEEN ONSET AND DEATH
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>General Debility</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <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 <u> </u> a.m. <u> </u> p.m. <u> </u>	Month, Day, Year <u> </u> <u> </u> <u> </u>		

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
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21. I attended the deceased from 1956 to 12-22-59 and last saw her alive on 12-22-59
Death occurred at 4:10 A.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>John R. Lawrence MD</u> (Degree or title)	22b. ADDRESS <u>Marshall, Missouri</u>	22c. DATE SIGNED <u>12-22-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-24-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Waverly, Missouri</u>	23d. LOCATION (City, town, or county) (State) <u>Waverly, Missouri</u>
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24. FUNERAL DIRECTOR <u>Sweeney-Keser Funeral Home</u>	ADDRESS <u>Marshall</u>	25. DATE RECD. BY LOCAL REG. <u>12-23-59</u>	26. REGISTRAR'S SIGNATURE <u>Cecil J. Keel</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

0001 P I MVT

JAN 14 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 Jack W. Reese

Licensed Embalmer No. 4643

P. O. Address Marshall

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