No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 15 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 9586 995

Registration District No. 399 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH:
(a) County: Jackson
(b) City or town: Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 345 N. Drury
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days) unknown
In this community unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Jackson
(c) City or town: Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No.: 345 N. Drury
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME: (N.M.O.) D. WARREN CHENEY
3. (b) If veteran, name war: No
3. (c) Social Security No.: No
4. Sex: Ma. 10
5. Color or race: W
6. (a) Single, widowed, married, divorced: married
6. (b) Name of husband or wife: Josephine Cheney
6. (c) Age of husband or wife if alive: unknown years
7. Birth date of deceased: Feb 1st 1859 (Month) (Day) (Year)
8. AGE: Years 82 Months 10 Days 21 If less than one day hr. min.
9. Birthplace: Ill (City, town, or county) (State or foreign country)
10. Usual occupation: Retired
11. Industry or business:
FATHER 12. Name: Jos. Cheney
13. Birthplace: unknown (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: Sarah Merriam
15. Birthplace: unknown (City, town, or county) (State or foreign country)
16. (a) Informant: Henry Wheeler
(b) Address: 345 N. Drury
17. (a) Burial: (Burial, cremation, or removal) (b) Date thereof: 3/12/41 (Month) (Day) (Year)
(c) Place: burial or cremation: Mound Grove Bailey Mo
18. (a) Signature of funeral director: M. Rogerson
(b) Address: KC
19. (a) Mch 11 1941 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day 3-2-41 year hour minute P. M.
21. I hereby certify that I attended the deceased from 3-15 19 to 19; that I last saw h. alive on 19; and that death occurred on the date and hour stated above.
Immediate cause of death: Chronic myocarditis
Due to:
Due to:
Other conditions (Include pregnancy within 3 months of death):
Major findings: Of operations: 93 F
Of autopsy: Inspection

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify):
(b) Date of occurrence:
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury:
23. Signature: Arcen R. Bulkley (M. D. or other)
Address: K.C. Mo Date signed 3-11-41

(Licensed Embalmer's Statement on Reverse Side)

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No. 3754

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

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