

3. No. 2  
4-1-42  
5-17-39  
1 x 1

5064

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 597

FILED FEB 25 1943

Registration District No. 149 Primary Registration District No. 1002

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Kansas City  
(c) Name of hospital or institution: St. Joseph Hospital  
(d) Length of stay: In hospital or institution since 1-26-43  
In this community St. as above

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County 97  
(c) City or town Marshall  
(d) Street No. X  
(e) Citizen of foreign country? no.  
If yes, name country X

3. (a) PRINT FULL NAME Warner W. Caton  
3. (b) If veteran, name war no. 3. (c) Social Security No. no.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Hallie Caton 6. (c) Age of husband or wife if alive Unknown  
7. Birth date of deceased September 17 1878

8. AGE: Years 64 Months 4 Days 18  
If less than one day 18 hr. \_\_\_\_\_ min.

9. Birthplace Missouri

10. Usual occupation Farmer

11. Industry or business X

12. Name T. W. Caton  
13. Birthplace Missouri  
14. Maiden name Unknown  
15. Birthplace Missouri

16. (a) Informant Mrs. Hallie Caton  
(b) Address Marshall, Missouri

17. (a) Removal (b) Date thereof 2-5-43

(c) Place: burial or cremation Marshall, Missouri

18. (a) Signature of funeral director Stine & McClure  
(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 2-5-43 (b) M. W. Crowe

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 5th year 1943 hour 2:00 minute A. M.  
21. I hereby certify that I attended the deceased from 1/26-43 to February 5 1943  
that I last saw him alive on February 4 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Lobar -  
Due to Trans. Uteri. Prostatic Resection  
Due to Uremia -  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Edema Prostatic Lobar  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address 1019 Prof. Bldg Date signed 2-5-43

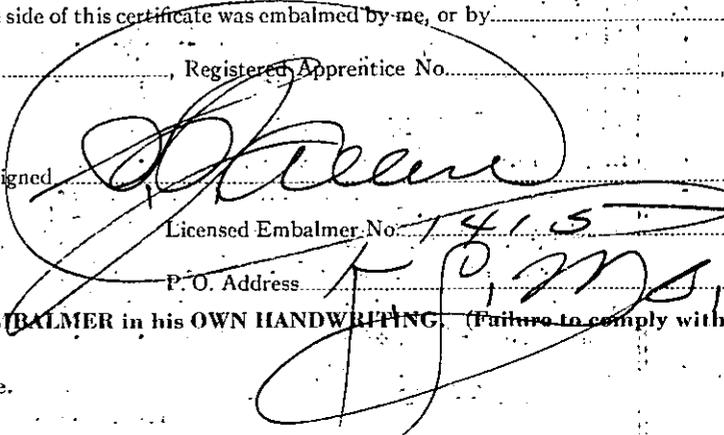
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

**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. 415  
P. O. Address R. J. M. S.

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