

FILED APR 7 1944

Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

Registrar's No. 1404

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:  
General Hospital No. 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3-22-44-3-28-44  
(Specify whether  
In this community 40 years (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 626 Cambell  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME FELIX SHERMAN WARFIELD

3. (b) If veteran, name war DONT KNOW 3. (c) Social Security No. NONE

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Widower  
6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased August 18 1864  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>79</u>	<u>7</u>	<u>8</u>	hr. _____ min.

9. Birthplace Sedalia Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Unemployed

11. Industry or business \_\_\_\_\_

12. Name Felix Warfield  
13. Birthplace Mo. 0  
(City, town, or county) (State or foreign country)  
14. Maiden name ?  
15. Birthplace unknown 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk  
(b) Address General Hospital No. 2

17. (a) BURIAL (b) Date thereof 3-30-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation HIGHLAND

18. (a) Signature of funeral director [Signature]  
(b) Address 1219 N. 1st St

19. (a) 3-29-44 (b) P. E. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 26  
year 1944 hour 6:30 minute P. M.

21. I hereby certify that I attended the deceased from March 22  
1944 to March 26, 1944;  
that I last saw him alive on March 26, 1944;  
and that death occurred on the date and hour stated above.

Immediate cause of death Senility with  
generalized Arteriosclerosis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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?  
\_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
Means of injury \_\_\_\_\_

23. Signature [Signature] (M.D. or other) \_\_\_\_\_

Address New Hope, Mo. E. 22 Date signed 3/27/44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING INK—MAKE A PERMANENT RECORD

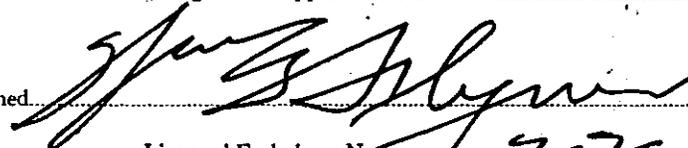
MOTHER FATHER

**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. 232

P. O. Address 1819 E. 15<sup>th</sup>

**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.**