F. S. No. 2
00M—2-43
ev. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 17 1945

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

5371

State File No. 643

Registration District No. 149 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: K. C. General Hospital No. 1 6
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 days (Specify whether years, months or days)
In this community 50 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No. 3002 Woodland 8
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Frank Warren
3. (b) If veteran, name war No
3. (c) Social Security No. 496-10-7097
4. Sex Male 0
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mamie Warren
6. (c) Age of husband or wife if alive 64 years
7. Birth date of deceased July (Month) 11 (Day) 1875 (Year)
8. AGE: Years 69 Months 6 Days 25 If less than one day hr. min.
9. Birthplace Coffeyville (City, town, or county) Kansas (State or foreign country)
10. Usual occupation Carpenter
11. Industry or business
FATHER 12. Name Robert H. Warren
13. Birthplace Illinois (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Caroline Tuckett
15. Birthplace Illinois (City, town, or county) (State or foreign country)
16. (a) Informant Mrs. Mamie Warren
(b) Address 3002 Woodland
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/8/45 (Month) (Day) (Year)
(c) Place: burial or cremation Smithville Missouri
18. (a) Signature of funeral director Mellody-McGilley
(b) Address Kansas City Mo.
19. (a) 2-8-45 (Date received local registrar) (b) D. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 6 year 1945 hour 4 minute 10 A.M.
21. I hereby certify that I attended the deceased from January 31, 1945 to February 6, 1945 that I last saw him alive on February 6, 1945 and that death occurred on the date and hour stated above.

| Immediate cause of death | Duration |
|---|---|
| Cerebral vascular accident | |
| Due to | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |

Major findings:
Of operations
Of autopsy None

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 0
23. Signature Clark W. Seely M.D. (M. D. or other)
Address Med. dir. Gen'l Hosp. Date signed 2-8-45

(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 Russell H France

Licensed Embalmer No. 4255

P. O. Address K. C. Mo

**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.**