No. 2
—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 27988

FILED AUG 18 1947

Registration District No. 147

Primary Registration District No. 1002

Registrar's No. 3415

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

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: 1409 Garfield (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 30 years years, months or days)

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. 1409 Garfield 8 (If rural, give location) 0
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Kathren Warren
3. (b) If veteran, name war no
3. (c) Social Security No. None
4. Sex Female 5. Color or race Negro
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife John
6. (c) Age of husband or wife if alive About 69 years
7. Birth date of deceased November (Month) 26 (Day) 1882 (Year)

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

9. Birthplace Beebe (City, town, or county) Ark. (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER
12. Name Louis Bryles
13. Birthplace Unknown (City, town, or county) (State or foreign country) 9
MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country) 7
16. (a) Informant Mrs. Delliah McCollins
(b) Address 1409 Garfield
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/9/'47 (Month) (Day) (Year)
(c) Place: burial or cremation Highland Cemetery
18. (a) Signature of funeral director E. Sterling Bills
(b) Address 1212 Vine St., K. C., MO.
19. (a) 8-9-47 (Date received local registrar) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug 4 day 47
year hour minute M.
21. I hereby certify that I attended the deceased from Aug 3 1947, to Aug 4 1947
that I last saw her alive on Aug 4 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Nephritis
Due to
Due to Uremia
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

Duration

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

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) 0
While at work? (e) Means of injury
23. Signature W. [illegible] (M. D. or other)
Address 1612 [illegible] Date signed 8/8/47

Jefferson City Printing Co.

(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 E. Sterling Billa

Licensed Embalmer No. 3178

P. O. Address 1212 Vine St., K. C.,

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.

S. No. 2B
3M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 149 Primary Registration District No. 1002. Registrar's No. 3415

SUPPLEMENTARY

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: 1409 Garfield
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 30 years
years, months or days)

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. 1409 Garfield
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Kathren Warren

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex

5. Color or race

6. (a) Single, widowed, married, divorced

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 8-9-47 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 4
year 1947 hour minute M.

21. I hereby certify that I attended the deceased from Aug. 3, 1947, to 8-4, 1947
that I last saw h. alive on 8-4, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Acute nephritis

Due to Chronic nephritis

Due to uremia

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 131 b

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? (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 L. W. Turner (M. D. or other)
Address 1612 E. 12th. Date signed 8-8-47

5-27988