

FILED MAR 12 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **5181**
745

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. LENGTH OF STAY (in this place) 30 yrs.	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		
d. FULL NAME OF HOSPITAL OR INSTITUTION 514 1/2 Main Street			d. STREET ADDRESS (If rural, give location) 514 1/2 Main Street		

3. NAME OF DECEASED (Type or Print) a. (First) Aldon b. (Middle) _____ c. (Last) Warner			4. DATE OF DEATH (Month) (Day) (Year) 2 16 49		
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5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH 2-28-1879	9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Months 11 Days 18	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME unknown		13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE xx	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Otis Warner (son) 1304 Askew, K. C. Mo.		
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 4201				INTERVAL BETWEEN ONSET AND DEATH
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19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION No Post Mortem		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) natural	21b. PLACE OF INJURY (e.g., in or about home [farm, factory, street, office bldg., etc.]) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____	

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE Hugh H. Owens (Degree or title) Coroner		23b. ADDRESS 1034 Piatt Bldg		23c. DATE SIGNED 2-17-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 2-18-49	24c. NAME OF CEMETERY OR CREMATORY Mt. Washington	24d. LOCATION (City, town, or county) (State) Kansas City, Missouri	
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DATE REC'D BY LOCAL REG. 2-17-49	REGISTRAR'S SIGNATURE Sheraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Peter B. Lapetina, 538 Campbell St. K.C. Mo.		
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WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

John B. Rozema

Licensed Embalmer No. _____

4223

P. O. Address _____

RCMO

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.