

FILED JUN 17 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 20535
2363

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 GENERAL HOSPITAL #2
d. STREET ADDRESS (If rural, give location) 1610 Kansas Avenue 3240

3. NAME OF DECEASED a. (First) THOMAS b. (Middle) c. (Last) WARREN
4. DATE OF DEATH (Month) (Day) (Year) MAY 13 1950

5. SEX MALE 2 6. COLOR OR RACE NEGRO 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED 2
8. DATE OF BIRTH MAY 22 1888 9. AGE (In years last birthday) 61

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) PRESCOTT, ARKANSAS 12. CITIZEN OF WHAT COUNTRY? U. S. A.

13a. FATHER'S NAME BYNA WARREN 13b. MOTHER'S MAIDEN NAME JANE
14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME ADDRESS
Hosp. Records K.C. Mo

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CEREBRAL VASCULAR ACCIDENT
INTERVAL BETWEEN ONSET AND DEATH
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.
ANTECEDENT CAUSES DUE TO (b) HYPERTENSIVE HEART DISEASE
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (c)
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.
4431

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES NO

21a. ACCIDENT (Specify) SUICIDE HOMICIDE 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) (Minute) 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-8, 19 50 to 5-13, 19 50 that I last saw the deceased alive on 5-13, 19 50 and that death occurred at 8:55 P.M., from the causes and on the date stated above.

23a. SIGNATURE E. Frank Ellis (Degree or title) 23b. ADDRESS 600 East 22nd Street 23c. DATE SIGNED 5-16-50

24a. BURIAL, CREMATION, REMOVAL (Specify) 24b. DATE 5/17/50 24c. NAME OF CEMETERY OR CREMATORY St. Louis University 24d. LOCATION (City, town, or county) (State) St. Louis MO

DATE REC'D BY LOCAL REG. 5-25-50 REGISTERAR'S SIGNATURE Geraldine Holmes 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS H.B. Moore 1820 E 18

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

H. B. Moore

Signed.....

Student Embalmer

Licensed Embalmer No. *2410*

P. O. Address *1820 E. 1st*

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.