

FILED FEB 6 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

194

BIRTH NO.		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		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 OR TOWN Kansas City		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION Westport Rest Home, 3940 McGee				e. STREET ADDRESS (If rural, give location) 705 West 47th Street					
3. NAME OF DECEASED (Type or Print) ROSELLA			a. (First)		b. (Middle)		c. (Last) WARNER		
4. DATE OF DEATH Jan. 13, 1956		4. DATE (Month) (Day) (Year)		5. SEX female		6. COLOR OR RACE white			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed		8. DATE OF BIRTH Nov. 5, 1864		9. AGE (In years last birthday) 91		IF UNDER 1 YEAR Months Days			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Newcomerstown, Ohio		12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME Thomas Lawhead			13b. MOTHER'S MAIDEN NAME Sarah Dudgeon			14. NAME OF HUSBAND OR WIFE Harry Warner			
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. none		17. INFORMANT'S SIGNATURE OR NAME Miss Kate B. Dawson, 750 W. 47 St., K.C. Mo.					
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, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Mitral lesion				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Dilatation of the heart				3 yrs.	
DUE TO (c) Chronic anemia secondary focal infection, probably death				II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Generalized pruritis				1 month.	
DUE TO (d) 5323								3 yrs.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		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) m.		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 <u>Jan. 65, 1953</u> , to <u>Jan. 13, 1956</u> , that I last saw the deceased <input checked="" type="checkbox"/> alive on <u>Jan. 9, 1956</u> , and that death occurred at _____ m., from the causes and on the date stated above.									
23a. SIGNATURE James W. Graham (Degree or title) James W. Graham M. D.				23b. ADDRESS 518 Argyle B ldg. K. C. Mo.		23c. DATE SIGNED 1/13/56			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 1-17-56		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) Newcomerstown, Ohio			
DATE REC'D BY LOCAL REG. 1-14-56		REGISTRAR'S SIGNATURE newa minshall		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS STINE & McCLURE UND. CO. K.C. MO.					

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

Rev. James W. Shabane
Argyle Bldg
Ha 1-5676

Epp

a 7

After 11:00 PM

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.....
Signature of Student Embalmer

Signed *Elmer D. Lytle*

Licensed Embalmer No. 4817

P. O. Address *Kansas City*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.