

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JAN 22 1957

State File No. **1500**  
Dist. **92**  
Registrar's No. **149**

BIRTH NO. _____		REG. DIST. NO. <b>149</b>		PRIMARY REG. DIST. NO. <b>1002</b>		Registrar's No. <b>149</b>			
1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Jackson</b>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kansas City</b>		c. LENGTH OF STAY (In this place) <b>30 yrs</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kansas City</b>					
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Wynne Rest Home</b>				d. STREET ADDRESS (If rural, give location) <b>220 170<sup>th</sup> E. 18<sup>th</sup> St.</b>					
3. NAME OF DECEASED (Type or Print) a. (First) <b>DOVIE</b>		b. (Middle) <b>W</b>		c. (Last) <b>WARREN</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Jan 6 1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>col.</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, <del>SEPARATED</del> <b>widowed</b>		8. DATE OF BIRTH <b>April 10 - 1880</b>			
9. AGE (In years last birthday) <b>76</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <b>Orcadia Okla.</b>			
12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>		13a. FATHER'S NAME <b>Dallas Warren</b>		13b. MOTHER'S MAIDEN NAME <b>Anne</b>		14. NAME OF HUSBAND OR WIFE <b>Robert Warren</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>495-09-5817</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Cabin Douglas 2439 Flora</b>					
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, ashenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Hypertensive Heart Disease</b> 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.				INTERVAL BETWEEN ONSET AND DEATH  <b>445<sup>h</sup></b>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
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 <b>1/4</b> , 19 <b>57</b> , to <b>1/6</b> , 19 <b>57</b> that I last saw the deceased alive on <b>1/4</b> , 19 <b>57</b> and that death occurred at <b>4:57</b> p.m., from the causes and on the date stated above.									
23a. SIGNATURE <b>S. Daigle, M.D.</b> (Degree or title) <b>0</b>				23b. ADDRESS <b>2122 Truman Rd</b>		23c. DATE SIGNED <b>1/7/57</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>1/8/57</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Lincoln</b>		24d. LOCATION (City, town, or county) (State) <b>Kansas City Mo</b>			
DATE REC'D BY LOCAL REG. <b>1-8-57</b>		REGISTRAR'S SIGNATURE <b>Howe Marshall</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Mrs. H. B. Moore</b>		ADDRESS <b>1974 Broadway</b>			

(Licensed Embalmer's Statement on Reverse Side)

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.....  
Student Embalmer

Signed

Licensed Embalmer No. 4429

P. O. Address 1300 End 1

**Note:** The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.