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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

FILED JAN 31 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 1590

Registration District No. 154 Primary Registration District No. 5575 Registrar's No. 5

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Grandview — Inside Limits Yes X No ☐
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Grandview Restorium — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City — Inside Limits Yes ☐ No X
d. STREET ADDRESS 99th & Holmes (If outside, give location) — Reside on Farm Yes ☐ No X

3. NAME OF DECEASED (Type or print): First Warren Middle Raymord Last Self
4. DATE OF DEATH: Month Jan Day 26 Year 1957
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH July 19,1875
9. AGE (In years last birthday) 81 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY GeneralFarming
11. BIRTHPLACE (City and state or country) Jackson Co.Missouri
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John M. Self
14. MOTHER'S MAIDEN NAME Annie Fitzwater
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) - - - - -
16. SOCIAL SECURITY NO.
17. INFORMANT Etta Sechrest, Address 8520 Euclid, K.C.Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma Metastatic — INTERVAL BETWEEN ONSET AND DEATH 3 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Carcinoma, Squamous cell of lip. — 2 yrs
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 191 X
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Nov 30, 1956 to Jan 26, 1957 and last saw him alive on Jan 7-57
Death occurred at 5:00 p m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Sam D Hooper (Degree or title) MD
22b. ADDRESS Grandview, Missouri
22c. DATE SIGNED 1-28-57

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 1-30-1957
23c. NAME OF CEMETERY OR CREMATORY Corinth, Cemetery
23d. LOCATION (City, town, or county) Johnson Co. Kansas (State)

24. FUNERAL DIRECTOR E.K.George &Sons, ADDRESS Grandview, Mo.
25. DATE RECD. BY LOCAL REG. 1-28-57
26. REGISTRAR'S SIGNATURE Sterling Edwards

(Licensed Embalmer's Statement on Reverse Side)

479

JAN 26 1957

MAY 14 1958

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Sterling E. Goddard

Licensed Embalmer No. 491

P. O. Address Grandview,

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (
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.