REG'D MAR 9 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

5474
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson
(b) Township Kaw
(c) City Kansas City
Registration District No. 399
Primary Registration District No. 1002
Registered No. 673
(d) Street No. 3933 Paseo St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred 45 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Karl Warner
(a) Residence, No. 3933 Paseo St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs. Anna Warner

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 9-11-1871

7. AGE: Years 67 | Months 5 | Days 3 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. Mechanic
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sweden

FATHER
13. NAME Andrew Larson
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sweden

MOTHER
15. MAIDEN NAME Elizabeth Peterson
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sweden

17. INFORMANT Mrs. Anna Warner
(ADDRESS) 3933 Paseo

18. BURIAL, CREMATION, OR REMOVAL
PLACE Forest Hill DATE 2-16-39, 19

19. FUNERAL DIRECTOR (NAME) Freeman Mortuary
(ADDRESS) Kansas City, Missouri

20. FILED Mar 16, 1939 M. M. Growie
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-14-39, 19

22. I HEREBY CERTIFY, That I attended deceased from Sept., 1935, to 2/14/39, 19
I last saw him alive on 2/14/39, 19 Death is said to have occurred on the date stated above, at 1:10P m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cardiac dilatation-decompensation	
Generalized oedema	

Other contributory causes of importance:

Chronic nephritis	
Chronic osteo-myelitis	

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) H. W. Kalberg, M. D.
(Address) 828 Medical Arts Bldg.

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

F. V. Hallberg
[illegible]
VA 5150
3:30-6

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 .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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

If this body is not embalmed, above space should be left blank.