

No. 2
4-13-40
5-17-39
I X23156

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **24063**
2602
Registrar's No. _____

FILED AUG 10 1941

Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH:
(a) County **Jackson**
(b) City or town **Kansas City**
(c) Name of hospital or institution: **St. Joseph Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **9 days**
In this community **Non-Resident** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Mr. Harley O. Warren**
3. (b) If veteran, name war **No** 3. (c) Social Security No. _____

4. Sex **Male** 5. Color or race **Wh** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Grace E. Warren** 6. (c) Age of husband or wife if alive **25** years
7. Birth date of deceased **May 25 1875**
(Month) (Day) (Year)

8. AGE: Years **66** Months **1** Days **14** If less than one day hr. _____ min. _____

9. Birthplace **Marshall Minn.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Salesman**

11. Industry or business **U. S. Line Co.**

12. Name **Ostrander Warren**

13. Birthplace **No Record**
(City, town, & county) (State or foreign country)

14. Maiden name " " 15. Birthplace " " (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Grace E. Warren**

(b) Address **Topeka, Kansas**

17. (a) **Removal** (b) Date thereof **7-9-41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Topeka, Kansas**

18. (a) Signature of funeral director **J. W. Wagner**
(b) Address **Kansas City, Mo.**

19. (a) **7-10-41** (b) **M. M. Browne**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Kansas** (b) County **Jackson**
(c) City or town **Topeka, Kansas**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? **2** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **9th** year **1941** hour **4** minute **5** AM.

21. I hereby certify that I attended the deceased from **July 5th 1941** to **July 9 1941** and that death occurred on the date and hour stated above.

Immediate cause of death: **Coronary Thrombosis**
Due to: **Post Operative Empyema**
Chronic

Other conditions: **110W**
(Include pregnancy within 3 months of death)

Major findings: **Chronic Empyema**
Of operations: _____
Of autopsy: **None**

Duration
Underline the cause to which death should be charged statistically.

PHYSICIAN

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) **NO**
(b) Date of occurrence **NO**

(c) Where did injury occur? **NO** (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? **NO**

(Specify type of place) (e) Means of injury

23. Signature **J. W. Wagner** (M. D. or D. O.)
Address **800 Perry Bldg** Date **7/10/41**

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

00338

S

Print Name

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.....

A. R. Hainisch

Licensed Embalmer No.....

4159

P. O. Address.....

K. C. Mo.

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.