

S. No. 2
M-5-42
V. 5-17-39
I X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27029

FILED SEP 7 1944

Registration District No. 1002

Primary Registration District No. 1002

Registrar's No. 3466

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

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: 115 South Lawn
(d) Length of stay: In hospital or institution 34 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(d) Street No. 115 South Lawn
(e) Citizen of foreign country? (Yes or No)

3. (a) PRINT FULL NAME MRS. ALICE M WARNER

3. (b) If veteran, name war No
3. (c) Social Security No. None

4. Sex Female / 5. Color or race White
6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Curtis Warner
6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased Oct 1 1883

8. AGE:	Years	Months	Days	If less than one day
	60	9	20	hr. min.

9. Birthplace Iowa

10. Usual occupation Housewife

11. Industry or business

12. Name John Martin
13. Birthplace Ireland
14. Maiden name Margaret Akin
15. Birthplace Penn

16. (a) Informant Curtis Warner
(b) Address 115 South Lawn

17. (a) Removal (b) Date thereof Aug 23, 1944
(c) Place: burial or cremation Creston, Iowa

18. (a) Signature of funeral director
(b) Address 20 West Linwood

19. (a) 8-23-44 (b) D. E. Brown

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 21 year 1944 hour 6:30 minute P. M.

21. I hereby certify that I attended the deceased from 6-29-44 to 8-21-44
that I last saw her alive on 8-21-44 and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of Gall Bladder
Duration of symptoms: 8 wks

Due to: Duration of symptoms

Other conditions: None
Major findings: No operation
Of operations: No
Of autopsy: No

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur?
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

23. Signature: M. J. Owens M.D.
Address: 1024 Health Bldg. K.C. Mo Date signed: 8-22-44

Dr. M. J. Owens.
Bristol Bldg.

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 comply with the above constitutes grounds for revocation of license.)

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