

Registration District No. 149 Primary Registration District No. 1002

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Gen. Hosp. #2 0  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 10-15-44-10-17-44  
(Specify whether  
In this community Unknown  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jackson 48  
(c) City or town Kansas City 3  
(If outside city or town limits, write "RURAL") 2  
(d) Street No. 2312 Highland  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME SOLOMON WARREN  
3. (b) If veteran, name war World War I 3. (c) Social Security No. #42-4-3270

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Oct. day 17  
year 1944 hour 5:15 minute A. M.  
21. I hereby certify that I attended the deceased from Oct. 15  
19 44 to Oct. 17, 19 44.  
that I last saw h. im alive on Oct. 17, 19 44.  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Wid  
6. (b) Name of husband or wife None - was 6. (c) Age of husband or wife if alive years  
7. Birth date of deceased December 23, 1885  
(Month) (Day) (Year)

Immediate cause of death Encephalomalacia of right brain Duration \_\_\_\_\_

8. AGE: Years 49 Months 9 Days 24 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
9. Birthplace Lopokas, Kansas  
(City, town, or county) (State or foreign country)

Due to Cerebral thrombosis - Arterio Sclerotic in type  
Due to \_\_\_\_\_

10. Usual occupation Unemployed  
11. Industry or business \_\_\_\_\_  
12. Name Jackson Warren  
13. Birthplace Brownville, Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary Baker  
15. Birthplace Lynchburg, Va.  
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) g3b  
Major findings: Of operations \_\_\_\_\_  
Of autopsy Same as above PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Record Clerk  
(b) Address Gen. Hosp. #2  
17. (a) Removal (b) Date thereof 10/20/44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Upper North End  
18. (a) Signature of funeral director W. E. Brown  
(b) Address 1729 Lydia Ave.  
19. (a) 10-20-44 (b) P. E. Brown  
(Date received local registrar) (Registrar's signature)

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? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
While at work? \_\_\_\_\_ (Specify type of place) Means of injury \_\_\_\_\_  
23. Signature W. E. Brown (M. D. or other) \_\_\_\_\_  
Address Gen. Hosp. #2 600 E. 22nd Date signed 10-19-44

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

OCT 30 1944

**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.....

*J. J. Malone*

Licensed Embalmer No. *3994*

P. O. Address. *2503 Highland*

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.