

FILED DEC 22 1944  
Registration District No. \_\_\_\_\_

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County **Jackson, Kansas City,**

(b) City or town **Kansas City,**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **2826 Harrison**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **no.** (Specify whether)

In this community **45 years,**  
years, months or days

3. (a) PRINT FULL NAME **Dr. Samuel Warner**

3. (b) If veteran, name war. **no.**

3. (c) Social Security No. **no.**

4. Sex **Male** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Widowed,**

6. (b) Name of husband or wife **Rose Ann Warner**

6. (c) Age of husband or wife if alive **dec.** years

7. Birth date of deceased: **January 14 1854**  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<b>90</b>	<b>10</b>	<b>29 28</b>	hr. min.

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

10. Usual occupation **Retired Minister**

11. Industry or business **Ministry**

12. Name **Warner,**

13. Birthplace **England**  
(City, town, or county) (State or foreign country)

14. Maiden name **Holmes,**

15. Birthplace **England**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Miss Gertrude Warner**

(b) Address **2826 Harrison, Kansas City, Mo.**

17. (a) **Burial** (b) Date thereof **12-14-44**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park Cemetery**

18. (a) Signature of funeral director **Stine & McClure,**

(b) Address **3235 Gillham Plaza, Kansas City, Mo.**

19. (a) **12-12-44** (b) **D. E. Brown**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson, 48**

(c) City or town **Kansas City,**  
(If outside city or town limits, write "RURAL")

(d) Street No. **2826 Harrison,**  
(If rural, give location)

(e) Citizen of foreign country? **no.** (Yes or No)

If yes, name country **x**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **December** day **12th**  
**1944** year. hour **11:45** minute **A.** M.

21. I hereby certify that I attended the deceased from **See 4**  
**1944** to **See 12**, **1944**.

that I last saw him alive on **See 9**, **1944**,  
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Occlusion** Duration **minutes**

Due to **Generalized Atherosclerosis** years

Due to \_\_\_\_\_

Other conditions: **94a**  
(Include pregnancy within 3 months of death)

Major findings: **94a**

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? **W. H. Hood** (Specify type of place) (f) Means of injury **MD**

23. Signature **W. H. Hood, M.D.** (M. D. or other)

Address **730 Professional Bldg** Date signed **12/14/44**

Dr. Goodson

*Robert H. Reed*

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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 *Robert H. Reed*

Licensed Embalmer No. *37457*

P. O. Address *Kansas City 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.**