S. No.
—12-45
5-17-39
PI X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 1 1947

Registration District No. 149

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1001

State File No. 9474

Registrar's No. 1352

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 General hospital No. 1 O
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day 3½ hrs. (Specify whether years, months or days)
In this community unknown

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")
(d) Street No. 1103 Chestnut 8
(If rural, give location)
(e) Citizen of foreign country? no. (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Florence Warner

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

3. (c) Social Security No. 492-14-2547

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Edwin M. Warner

6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased Feb 12 (Month) 1887 (Day) (Year)

8. AGE: Years 60 Months 1 Days 9 If less than one day hr. min.

9. Birthplace Springfield Ill. (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER
12. Name Arnold
13. Birthplace Do (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name not
15. Birthplace Known (City, town, or county) (State or foreign country)

16. (a) Informant Edwin M. Warner
(b) Address 1103 Chestnut

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/24/47 (Month) (Day) (Year)
(c) Place: burial or cremation Mt Washington

18. (a) Signature of funeral director Parentis Bros
(b) Address K. C. Mo.

19. (a) 3-22-47 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 21 year 1947 hour 3 minute 45 A.M.

21. I hereby certify that I attended the deceased from March 20, 1947, to March 21, 1947, that I last saw her alive on March 21, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Acute toxemia
Cause undetermined

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy See above

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

23. Signature Wm. W. Hart (M.D. or other) MD
Address Med. Dir. Gen'l Hosp. Date signed 3-21-47

(Licensed Embalmer's Statement on Reverse Side)

No Record

FEB 4 1959

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 Thomas Walton

Licensed Embalmer No. 2744

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.

S. No. 2B
25M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1352

SUPPLEMENTARY

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. #1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Florence Warner

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex

5. Color or race

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

6. (b) Name of husband or wife

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

7. Birth date of deceased (Month) (Day) (Year)

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

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

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

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 3-22-47 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month March day 21
year 1947 hour 3 minute 45a M.

21. I hereby certify that I attended the deceased from March 20, 1947, to 3-21, 1947
that I last saw her alive on 3-21, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Acute toxemia
Cause undetermined
(n-m-o.)

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death) 66 A

Major findings:
Of operations

Of autopsy see above

Duration

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature Wm. W. Hart (M. D. ~~or other~~)

Address Gen. Hosp. #1 Date signed 3-21-47

9474