

FILED JUN 25 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 19864  
Registrar's No. 2483

BIRTH NO.		REG. DIST. NO. 149	PRIMARY REG. DIST. NO. 1002	Registrar's No. 2483
1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. LENGTH OF STAY (in this place) 35 yrs.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City
d. FULL NAME OF HOSPITAL OR INSTITUTION General Hospital #2		d. STREET ADDRESS (If rural, give location) 1723 Lydia Ave. Rear		
3. NAME OF DECEASED (Type or Print) Arthur Warren a. (First) b. (Middle) c. (Last)			4. DATE OF DEATH June 5, 1949 (Month) (Day) (Year)	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH July 26, 1883	9. AGE (In years last birthday) 65 IF UNDER 1 YEAR: Months Days IF UNDER 12 HRS: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Columbia, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Willis Warren		13b. MOTHER'S MAIDEN NAME Elija Bryant	14. NAME OF HUSBAND OR WIFE Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mollie Grant - 1610 Admiral Blvd.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Shock ANTECEDENT CAUSES DUE TO (b) Subdural Hematoma DUE TO (c) Injury By Fall II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. E9020 21		INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Deputy Coroner		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 1723 Lydia	21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE) Kansas City MO		
21d. TIME OF INJURY 6 3 49	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? fell down stairs 23		
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.				
23a. SIGNATURE A.E. Upsher		23b. ADDRESS Mo. 2800 main		23c. DATE SIGNED 6/8/49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6-8-49	24c. NAME OF CEMETERY OR CREMATORY Highland	24d. LOCATION (City, town, or county) (State) K.C. Mo.	
DATE REC'D BY LOCAL REG. 6-7-49	REGISTRAR'S SIGNATURE Geraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Watkins Bros. 1729 Lydia		

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

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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.....

..... Student Embalmer No. ....

working under my personal supervision.

Signed.....

Signed.....  
Student Embalmer

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.