

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31916**
4095

o. 300
o. 48

REC'D SEP 27 1952

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

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. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
c. LENGTH OF STAY (in this place) 4 yrs		d. STREET ADDRESS (If rural, give location) 4433 1/2 Forest	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Hospital			

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3. NAME OF DECEASED (Type or Print) a. (First) GEULAH		b. (Middle)		c. (Last) WARREN		4. DATE OF DEATH (Month) (Day) (Year) 9 13 52	
5. SEX Fe		6. COLOR OR RACE Wh		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 12-28-1898	
9. AGE (In years last birthday) 53		IF UNDER 1 YEAR Months		IF UNDER 1 YEAR Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home			11. BIRTHPLACE (City and State or Foreign Country) Appleton City, Mo.	
						12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Gern Van Buskirk		13b. MOTHER'S MAIDEN NAME Ora Caton		14. NAME OF HUSBAND OR WIFE John S. Warren	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS John S. Warren, 4433 1/2 Forest	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinomatosis		DUE TO (b) Carcinoma of sigmoid colon		Indef.	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (c)		4 yrs	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				153A	

19a. DATE OF OPERATION Feb. 1947		19b. MAJOR FINDINGS OF OPERATION Carcinoma of sigmoid colon		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR	
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22. I hereby certify that I attended the deceased from **Nov. 11, 1947** to **9-13-**, 19**52**, that I last saw the deceased alive on **9-13-**, 19**52**, and that death occurred at **11:30 p** m., from the causes and on the date stated above.

23a. SIGNATURE Ernest G. Neighbor (Degree or title) MD		23b. ADDRESS 1420 S. 42nd, Kansas City 6, Kans		23c. DATE SIGNED 9-16-52	
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24a. BURIAL OR CREMATION REMOVAL (Specify) Burial		24b. DATE 9-24-52		24c. NAME OF CEMETERY OR CREMATORY Appleton City Cem.		24d. LOCATION (City, town, or county) (State) Appleton City, Mo.	
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DATE REC'D BY LOCAL REG. 9-16-52		REGISTRAR'S SIGNATURE Seraldine Holmes		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J.W. Wagner K 6 Mo.	
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(Licensed Embalmer's Statement on Reverse Side)

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

File 6060
3:30 P.M.

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.

Student
Student Embalmer

Signed Alvin R. Harnscheidt

Licensed Embalmer No. 4159

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.