

150 MAR 15 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **5160**  
**697**

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

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Kansas City</b>	c. LENGTH OF STAY (in this place) <b>30 Yrs.</b>	c. CITY OR TOWN <b>Kansas City</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>3226 E. 10th. Street</b>		STREET ADDRESS (If rural, give location) <b>3226 E. 10th</b> <b>3188</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Juda</b> b. (Middle) <b>Elizabeth</b> c. (Last) <b>Warren</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>February 14 1955</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>July 3 1867</b>	9. AGE (In years last birthday) <b>87</b>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Homemaking</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Warsaw, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>

13a. FATHER'S NAME <b>Samuel Akin</b>		13b. MOTHER'S MAIDEN NAME <b>Malva McMullin</b>		14. NAME OF HUSBAND OR WIFE <b>John L. Warren</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Julius Warren; 1515 Holmes</b>	

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, asthenia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 mth</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Hypertension</b>		
	DUE TO (c) <b>Arteriosclerosis generalized</b>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			<b>331X</b>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-5 1954 to 2-14, 1955, that I last saw the deceased alive on 2-14, 1955, and that death occurred at 9:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE <b>J. M. Haight</b> (Degree or title)	23b. ADDRESS <b>3401 East 12th. St. K. C. Mo.</b>	23c. DATE SIGNED <b>2-15-55</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Feb 17 1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Floral Hills</b>
24d. LOCATION (City, town, or county) (State) <b>Kansas City Missouri</b>		

DATE REC'D BY LOCAL REG. <b>2-15-55</b>	REGISTRAR'S SIGNATURE <b>Neva Marshall</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>FLORAL HILLS MEMORIAL CHAPELS, INC., K.C. MO</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

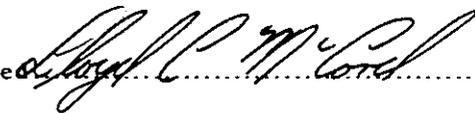
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STATEMENT BY LICENSED EMBALMER

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..

Student.....  
Signature of Student Embalmer

Signed  .....

Licensed Embalmer No. 485

P. O. Address T. C. ....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.