

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **20785**  
**2709**

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>KANSAS</b> b. COUNTY <b>JOHNSON</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>KANSAS CITY</b>	c. LENGTH OF STAY (In this place) <b>13 MO.</b>	c. CITY OR TOWN <b>KANSAS CITY</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>100 EAST 37-36TH STREET COLONIAL NURSING HOME</b>		e. STREET ADDRESS (If rural, give location) <b>9841 OVERBROOK ROAD</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>MINNIE</b>	b. (Middle) <b>A.</b>	c. (Last) <b>WARREN</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>JUNE-19-1956</b>
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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>SEPT-27-1872</b>	9. AGE (In years last birthday) <b>83</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>WINDSOR MISSOURI</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>F. C. ARNOLD</b>	13b. MOTHER'S MAIDEN NAME <b>DRUCELLA GOODWIN</b>	14. NAME OF HUSBAND OR WIFE <b>WALTER WARREN</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT'S SIGNATURE OR NAME <b>MRS. LOWELL JOHNSON</b>	ADDRESS <b>9841 OVERBROOK RD. KANSAS CITY, MO.</b>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Lymphoid Sarcoma</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 yr</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b)  DUE TO (c)		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **6/19, 1956** to **6/19, 1956** that I last saw the deceased alive on **6/19, 1956** and that death occurred at **4:00 p. m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>H. C. Trippe</b>	(Degree or title) <b>M.D.</b>	23b. ADDRESS <b>6247 Brookside</b>	23c. DATE SIGNED <b>6/19/56</b>
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24a. BURIAL CREMATION REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>JUNE 19 1956</b>	24c. NAME OF CEMETERY OR CREMATORY <b>LAUREL OAK CEMETERY</b>	24d. LOCATION (City, town, or county) (State) <b>WINDSOR MISSOURI</b>
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DATE REC'D BY LOCAL REG. <b>6-20-56</b>	REGISTRAR'S SIGNATURE <b>Neva Marshall</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>D.H. Newcomer</b>	ADDRESS <b>1331 BROWN CREEK KANSAS CITY, Mo.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

0.300  
0.48

JUL 22 1957

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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 Rollie Kessel.....

Licensed Embalmer No. 4690

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.