

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-005952
STATE FILE NUMBER 547

FEB 17 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

300
-57

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Research Hosp.		Length of stay in lb 20 yrs.	d. STREET ADDRESS (If outside, give location) 3617 Morrell Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last Edward Dwight Warren			4. DATE OF DEATH Month Day Year Jan. 25, 1959		
--	--	--	---	--	--

5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 25, 1893	9. AGE (In years last birthday) 65	10. FUNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
-------------	------------------------	---	---------------------------------	------------------------------------	---	----------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate	10b. KIND OF BUSINESS OR INDUSTRY Builder	11. BIRTHPLACE (City and state or country) Arkansas	12. CITIZEN OF WHAT COUNTRY? U. S. A.
--	--	--	--

13a. FATHER'S NAME Unknown- Edward D. Warren	13b. MOTHER'S MAIDEN NAME Unknown- Evelyn	14. NAME OF HUSBAND OR WIFE Nancy Nell Warren
---	--	--

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. 497-36-5972	17. INFORMANT Nancy Nell Warren	Address 3617 Morrell
---	--	------------------------------------	-------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
---	--

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
--	---	--	---

21. I attended the deceased from <u>6-22-58</u> to <u>6-25-59</u> and last saw her alive on <u>1-24-59</u> Death occurred at <u>4:50 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Martin J. Mueller M.D.</u>	22b. ADDRESS <u>535 Angles Bldg, CCMO</u>	22c. DATE SIGNED <u>1-26-59</u>
---	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1/28/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City Mo.</u>
--	-----------------------------	--	---

24. FUNERAL DIRECTOR <u>Stine & McClure</u>	ADDRESS <u>K. C. Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>1-28-59</u>	26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>
--	-----------------------------	--	---

(Licensed Embolmer's Statement on Reverse Side)

Martin J. Mueller
MEDICAL CERTIFICATION
All diseases in Part I must be causally related.

1/2-2-84-207
1/2-2-84-207

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 *William M. Turner*

Licensed Embalmer No. *4648*
P. O. Address *Lawrence 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.