

Health, Welfare Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-009725
STATE FILE NUMBER
1392

FILED APR 2 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1392

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1. PLACE OF DEATH a. COUNTY <i>Jackson</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Jackson</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Kansas City</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Kansas City</i>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Gen. Hospital</i>		Length of stay in 1b 10 YEARS	d. STREET ADDRESS (If outside, give location) <i>2816 E 12th</i>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <i>Anna</i> Middle <i>E.</i> Last <i>WARREN</i>			4. DATE OF DEATH Month <i>3</i> Day <i>13</i> Year <i>59</i>			
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5. SEX <i>Female</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JUNE 6, 1883</i>	9. AGE (In years at birthday) <i>75</i>	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) <i>AT HOME</i>	10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (City and state or country) <i>HIGGINSVILLE, MISSOURI</i>	12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
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13a. FATHER'S NAME <i>JOHN HICKLIN</i>	13b. MOTHER'S MAIDEN NAME <i>MARY T. ASHBY</i>	14. NAME OF HUSBAND OR WIFE <i>JOHN L. WARREN</i>
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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) <i>NO</i>	16. SOCIAL SECURITY NO. <i>NONE</i>	17. INFORMANT <i>MRS. EFFIE WINKER</i>	<i>2816 EAST 12TH STREET</i> <i>KANSAS CITY, MISSOURI</i>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Broucho pneumonia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 1/2</i>
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) <i>Perianal abscess with ulceration</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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.)
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20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____	20d. INJURY OCCURRED WHILE AT WORK <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 _____
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21. I attended the deceased from <i>2-15-59</i> to <i>3-13-59</i> and last saw her ^{her} alive on <i>3-13-59</i> Death occurred at <i>9:55 AM</i> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <i>Abraham Gelpin</i>	22b. ADDRESS <i>Gen. Hospital</i>	22c. DATE SIGNED <i>3-13-59</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE <i>MARCH 16, 1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>WELLINGTON CEMETERY</i>	23d. LOCATION (City, town, or county) (State) <i>WELLINGTON, MISSOURI</i>
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24. FUNERAL DIRECTOR <i>D. W. NEWCOMER'S SONS KANSAS CITY, Mo.</i>	25. DATE RECD. BY LOCAL REG. <i>3-16-59</i>	26. REGISTRAR'S SIGNATURE <i>Neva Marshall</i>
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(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.
Abraham Gelpin M.D. Use ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Rasil Honey*

Licensed Embalmer No. *1724*
P. O. Address *A. I. Me*

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.