

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

40879

1. PLACE OF DEATH

County Jackson
Township Raw
City Kansas City (No. Old City Hospital)

Registration District No. _____
Primary Registration District No. _____

File No. _____
Registered No. 5256 St. _____ Ward _____

2. FULL NAME

Allen, Willie
(a) Residence No. 410 E 5th St. 9 Ward.

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Nellie Allen

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 14, 1891

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ____ hrs. or ____ min.
	37	3	28	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) Labor
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Lawrence
(STATE OR COUNTRY) Kansas

10. NAME OF FATHER William Allen

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Kentucky

12. MAIDEN NAME OF MOTHER Beanie Jordan

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Kentucky

14. INFORMANT Nellie Allen, Wife
(Address) Lawrence Kans

15. FILED 12/19/28 M. M. Corvise REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) December 7 1928
17. 3

I HEREBY CERTIFY, That I attended deceased from November 7, 1928 to December 7, 1928 that I last saw him alive on December 7, 1928, and that death occurred, on the date stated above, at 4:25 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocardial failure
Toxaemia 43D
67K3
88
(duration) 1 yrs. 1 mos. 0 da.

CONTRIBUTORY (SECONDARY) Alimentary Process
(duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____
DID AN OPERATION PRECEDE DEATH: No. DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS Lab. Physical
(Signed) W. M. Smith M. D.
12/8, 1928 (Address) Old City Hospital

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL K.C. Western Dental School DATE OF BURIAL 12/17 1928

20. UNDERTAKER Mo state Anatomical Board ADDRESS of Atchafalaya

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

K. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

