

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

17562

State File No.

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 2089

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Lukes Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community Nine years
years, months or days)

3. (a) PRINT FULL NAME CHARLES LEO ALLEN 450

3. (b) If veteran, name war No 3. (c) Social Security No. 487-03-5351

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Jennie M. Allen 6. (c) Age of husband or wife if alive 53 years

7. Birth date of deceased October 28, 1890
(Month) (Day) (Year)

8. AGE: Years 49 Months 6 Days 20 If less than one day _____ hr. _____ min.

9. Birthplace Larkin Michigan
(City, town, or county) (State or foreign country)

10. Usual occupation Chef Pickwick Hotel 7

11. Industry or business Cooking

12. Name William Allen 9

13. Birthplace Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Johanna Unknown

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Jennie Allen

(b) Address Chase Hotel, 911 Holmes St.

17. (a) Burial (b) Date thereof 5/21/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland Park, K.C.K.

18. (a) Signature of funeral director W. H. Heng

(b) Address 10 and Barnett, K.C.K.

19. (a) May 21, 1940 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. Chase Hotel, 911 Holmes St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 18
year 40 hour P minute P M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Calciphylax of left hand and arm
Acute Cellulitis lymph nodes
Due to Sepsis

Due Acute of left hand (History)

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy See above

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence Party part of road, definitely

(c) Where did injury occur Pickwick Hotel, K.C. Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? See see c.

While at work _____ (Specify type of place) (e) Means of injury Burn

23. Signature W. H. Heng (M. F. Heng)

Address 10 and Barnett Date signed 5/21/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

C

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed

Chas. H. Rider

Licensed Embalmer No. *3404*

P. O. Address *Kansas 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 this body is not embalmed, above space should be left blank.

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State File No. _____

Registration District No. _____

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1. PLACE OF DEATH:

(a) County _____
(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 18
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to Cellulitis of left hand and arm
Due to Burn of left hand
Other conditions Mild erysipelas
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Underline (the cause to which death should be charged statistically).

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence May 1940
(c) Where did injury occur Guchman Hotel (City or town) _____ (County) _____ (State) _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Not a Conflagration!
While at work? _____ (Specify type of place)
(e) Means of injury Burns

23. Signature Leitch (M. D. of other) _____
Address _____ Date signed _____

3. (a) PRINT FULL NAME Charles Leo Allen

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex _____ 5. Color or race _____ 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 5/21/40 (b) M. M. Crowe (Date received local registrar) (Registrar's signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

S-17562

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.