No. 2
1-10-39
17-39
X21492

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

FILED AUG 9 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24705

Registration District No. 85 — Primary Registration District No. 1001 — Registrar's No. 831

1. PLACE OF DEATH:

(a) County: Buchanan
(b) City or town: Saint Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1125 Powell Street 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)
In this community: 10 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Buchanan
(c) City or town: Saint Joseph
(If outside city or town limits, write "RURAL")
(d) Street No.: 1125 Powell Street
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

8. (a) PRINT FULL NAME: Lee Andrew Allen 450
8. (b) If veteran, name war: Spanish War
8. (c) Social Security No.: 491-09-1117

4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Mrs. Agnes L. Allen
6. (c) Age of husband or wife if alive: 58 years
7. Birth date of deceased: September (Month) 2 (Day) 1880 (Year)

8. AGE: Years	Months	Days	If less than one day
59	10	28	hr. _____ min.

9. Birthplace: Roff (City, town, or county) Iowa (State or foreign country) 1
10. Usual occupation: Police Lieutenant 4
11. Industry or business: 9
MOTHER FATHER
12. Name: Amos Allen 1
13. Birthplace: Unknown. (City, town, or county) Unknown (State or foreign country)
14. Maiden name: Sarah Lenord
15. Birthplace: Unknown (City, town, or county) Unknown (State or foreign country)
16. (a) Informant: Owida Kearn
(b) Address: Kansas City, Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug. 1, 1940 (Month) (Day) (Year)
(c) Place: burial or cremation: Ashland Cemetery
18. (a) Signature of funeral director: Mrs E R Sidenfaden Funeral Home
(b) Address: 602 South 10th Street
19. (a) 7/31/40 (Date received local registrar) (b) H J Nesselbush (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 30
year 1940 hour 5 8 minute 9 A. M.
21. I hereby certify that I attended the deceased from 10-1, 1937, to 7/30, 1940
that I last saw him alive on 7-25, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pulmonary Tuberculosis with Cavitation	about 30 years
Due to: T B	
Due to:	
Other conditions: Tuberculosis of intestines (Includes pregnancy within 3 months of death)	

Major findings of operations: —
Of autopsy: Pulmonary tuberculosis with cavitation, T.B. ulceration of intestines

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
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work (e) Means of injury

23. Signature: David J. Rosenthal (M. D. or other) M. D.
Address: Central Bldg Date signed: 7-30-40

(Licensed Embalmer's Statement on Reverse Side)

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.....

Mollie E. Sidenfaden, Registered Apprentice No. 145

working under my personal supervision.

Signed A. V. Wenst.

Licensed Embalmer No. 3876

P. O. Address St Joseph M

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.