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K21492

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 27627  
3261

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Kansas  
(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. Joseph Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 weeks  
(Specify whether \_\_\_\_\_)  
In this community 6 years  
years, months or days Blanche Berry Allen

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Jackson  
(c) City or town Mo  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5525 Wayne  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME BLANCHE BERRY ALLEN

3. (b) If veteran, name war NO 3. (c) Social Security No. 42

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

6. (b) Name of husband or wife Wynne Allen 6. (c) Age of husband or wife if alive 7 years

7. Birth date of deceased Mar 8 1873  
(Month) (Day) (Year)

8. AGE: Years 67 Months 5 Days 8 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation H W

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Henry Samuel  
13. Birthplace unknown Ohio  
(City, town, or county) (State or foreign country)  
14. Maiden name Anna Hester  
15. Birthplace unknown Ohio  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Nettie Beenz  
(b) Address 704 E mo R8

17. (a) Cameron mo (b) Date thereof Aug 18-40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Cameron mo

18. (a) Signature of funeral director Worton Funnell  
(b) Address not Kansas City mo

19. (a) Aug. 18, 1940  
(Date received local registrar) (Registrar's signature) M-M-Crowe

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 16 - year 40  
hour \_\_\_\_\_ minute 2:10 P.M.

21. I hereby certify that I attended the deceased from 7-30-40, 19\_\_\_\_, to 8-16-40, 19\_\_\_\_;  
that I last saw er alive on 8-16-40, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Encephalomalacia  
Due to Hypotensive myocardia  
Due to Chronic Vascular Nephrosis  
Other conditions 121  
(Include pregnancy within 3 months of death)

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

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

23. Signature [Signature] (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
(M. D. or other) \_\_\_\_\_  
Address [Signature] Date signed \_\_\_\_\_

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

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**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 the above constitutes grounds for revocation of license.)**

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