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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

194 STANDARD CERTIFICATE OF DEATH

State File No. 20813

Registration District No. FILED JUL 7 399

Primary Registration District No. 100

Registrar's No. 2343

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: General Hospital #2 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5-15-41-6-2-41 (Specify whether years, months or days)
In this community 60 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo. (b) County: Jackson
(c) City or town: Kansas City (If outside city or town limits, write "RURAL")
(d) Street No. 1019½ Independence (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Carrie Allen
3. (b) If veteran, name war: Unk
3. (c) Social Security No.: Unk
4. Sex: Female
5. Color or race: Negro
6. (a) Single, widowed, married, divorced: Widow
6. (b) Name of husband or wife: Unknown
6. (c) Age of husband or wife if alive: — years
7. Birth date of deceased: Unknown (Month) (Day) (Year)

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

9. Birthplace: Warrensburg (City, town, or county) Mo. (State or foreign country)
10. Usual occupation: Unemployed
11. Industry or business:
FATHER 12. Name: Unk
FATHER 13. Birthplace: (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: Unk
MOTHER 15. Birthplace: (City, town, or county) (State or foreign country)
16. (a) Informant: Record Clerk
(b) Address: General Hospital #2
17. (a) Interment (Burial, cremation, or removal): Lakeview (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation: Kansas City, Mo.
18. (a) Signature of funeral director: Collegiate Osteopathy
(b) Address: 2000 E. 12th
19. (a) 6/20/41 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 2 year 41 hour 11 minute 50 P. M.
21. I hereby certify that I attended the deceased from 5-15- 1941 to 6-2- 1941 that I last saw her alive on 6-2- 1941 and that death occurred on the date and hour stated above.

Immediate cause of death: Broncho-Pneumonia (Hypostatic)
Due to: Arteriosclerosis
Due to:
Other conditions (Include pregnancy within 3 months of death): 107

Duration

Major findings:
Of operations:
Of autopsy:

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: P. O. Quinn (M. D. or other)
Address: Gen. Hosp. #2 Date signed 6-5-41

(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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed.....

Licensed Embalmer No. 3836

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, fact should be so stated above.