

**FILLED SEP 12 1941**

Registration District No. 299

Primary Registration District No. 1002

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

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: K.C. General Hospital No. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 days  
In this community 35 years 0 (Specify whether years, months or days)

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. 547 Walnut  
(If rural, give location)  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

WILLIAM ALLEN

3. (b) If veteran, name war

No record

3. (c) Social Security No.

—

4. Sex M. 0

5. Color or race W.

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased January 3rd 1851

(Month) (Day) (Year)

8. AGE:

Years 90 Months 7 Days 3 If less than one day  
br. min.

9. Birthplace

Indiana  
(City, town, or county) (State or foreign country)

10. Usual occupation

None

11. Industry or business

MOTHER FATHER

12. Name James Allen

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

14. Maiden name Susan Grovendyke

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

16. (a) Informant

Record Clerk

(b) Address

K.C. General Hospital K.C. Mo.

17. (a)

Burial

(b) Date thereof

8-18-41

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation State Anatomical Board

18. (a) Signature of funeral director

W. A. Lohmeyer

(b) Address

City mortician

19. (a)

9/15/41  
(Date received local registrar)

(b)

M. M. Brown  
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 6th  
year 1941 hour 8 minute 55 P. M.

21. I hereby certify that I attended the deceased from 8-2-41, 19— to 8-6-41, 19—  
that I last saw him alive on 8-6-41, 19—  
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic bronchopneumonia  
Due to Myocardial insufficiency, congestive

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
Major findings: 107  
Of operations \_\_\_\_\_  
Of autopsy None

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 Druey R. Shan (M. D. or other) D  
Address Med. Dir. K.C. Gen. Hospital Date signed \_\_\_\_\_

**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 *Wm A. Johnson*

Licensed Embalmer No. *3089*

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.**