. S. No. 2
OM—5-42
5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 25 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 8964

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1335

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: 419 Ward Parkway - 1st Floor /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ---- (Specify whether
In this community 40 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48 3

(c) City or town Kansas City 8
(If outside city or town limits, write "RURAL")

(d) Street No. 419 Ward Parkway-1st Floor
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country ---- 0

3. (a) PRINT FULL NAME Mrs. Linnie Leona Allen

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female

5. Color or race White /

6. (a) Single, widowed, married, divorced Widowed 2

6. (b) Name of husband or wife Dr. Charles Channing Allen

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

7. Birth date of deceased October (Month) 20 (Day) 1871 (Year)

8. AGE: Years 71 Months 4 Days ~~28~~ 27 If less than one day hr. min.

9. Birthplace Leavenworth (City, town, or county) Kansas / (State or foreign country)

10. Usual occupation At Home

11. Industry or business -----

FATHER
12. Name George Ummethum
13. Birthplace (City, town, or county) Germany 4 (State or foreign country)

MOTHER
14. Maiden name Martha Austin
15. Birthplace (City, town, or county) Ohio / (State or foreign country)

16. (a) Informant Mrs. Josephine O'Rear
(b) Address 419 Ward Parkway

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 19, 1943 (Month) (Day) (Year)
(c) Place: burial or ~~cremation~~ Mt. Muncie Cemetery Leavenworth, Kansas

18. (a) Signature of funeral director D. N. Newcomer's Sons
(b) Address 1401 Brush Creek Blvd.

19. (a) 3-18-43 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 17 day March
year 1943 hour minute 3 P. M.

21. I hereby certify that I attended the deceased from Jan 10, 1943 to March 17, 1943
that I last saw her alive on March 12, 1943
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral apoplexy	1 hour
Due to:	
Due to: General vascular sclerosis	2 yrs.
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations: 83	
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 A. Morris Gusberg O (M. D. or other) MD

Address 420 Prof Bldg Date signed 3-17-43

(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 H. O. Newcomer Jr

Licensed Embalmer No. 4043

P. O. Address K. C. 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, fact should be so stated above.