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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 5 1944

Registration District No. 199

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 13550

Primary Registration District No. 1002

Registrar's No. 1223

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: 309 Garfield (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 35 years

2. USUAL RESIDENCE OF DECEASED: 48
(a) State Missouri (b) County Jackson 3
(c) City or town Kansas City, Missouri (If outside city or town limits, write "RURAL") 20 8
(d) Street No. 1218 Forest (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country No 0

3. (a) PRINT FULL NAME Charles L. Allee
3. (b) If veteran, name war No
3. (c) Social Security No. 495-03-1996

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife May Allee
6. (c) Age of husband or wife if alive 55 years
7. Birth date of deceased November (Month) 26 (Day) 1874 (Year)

8. AGE: Years 69 Months 4 Days 21 20 If less than one day hr. min.

9. Birthplace Clarksburg, (City, town, or county) Missouri 0 (State or foreign country)
10. Usual occupation Pharmist
11. Industry or business

FATHER
12. Name No record
13. Birthplace No record (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name no record
15. Birthplace No record (City, town, or county) 9 (State or foreign country)

16. (a) Informant Mrs. May Allee
(b) Address 1218 Forest K.C., Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-18-44 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Moriah
18. (a) Signature of funeral director Wornall Funeral Home
(b) Address Kansas City Mo.
19. (a) 4-19-44 (Date received local registrar) (b) N. E. Brown (Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 16 year 1944 hour 7 minute 30 A.M.

21. I hereby certify that I attended the deceased from March 15 1943 to April 16 1944 that I last saw him alive on April 15 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Coronary Thrombosis	4
Due to: Arteriosclerosis	C
Due to: Hypertension	C
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations: 9	
Of autopsy: Sclerosis, Vessels. Thrombus, Coronary	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(c) 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 John T. Henry (M. D. or other) MD
Address 210 Brotherhood Bldg. K.C. Mo. Date signed 4-18-44

(Licensed Embalmer's Statement on Reverse Side)

1815-E75

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 Harlyn Roe

Licensed Embalmer No. 7810

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.