DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 26721

FILED AUG 23 1944

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3336

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 O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8/8 to 8/9 (Specify whether
In this community 20 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 4

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

(d) Street No. 1415 Michigan
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Hoyt L. Allen

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male 2

5. Color or race Col

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

6. (b) Name of husband or wife Minnie Allen

6. (c) Age of husband or wife if alive 44 years

7. Birth date of deceased January 7, 1899
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
45	7	2	hr. min.

9. Birthplace Colorado Springs (City, town, or county) Colo. (State or foreign country)

10. Usual occupation Window Washer

11. Industry or business

FATHER
12. Name Thomas Allen
13. Birthplace Louisville (City, town, or county) Kentucky (State or foreign country)

MOTHER
14. Maiden name Mary Baxter
15. Birthplace Canton (City, town, or county) Miss. (State or foreign country)

16. (a) Informant Minnie Allen
(b) Address 1415 Michigan

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 8/16/44 (Month) (Day) (Year)
(c) Place: burial or cremation Highland Cemetery

18. (a) Signature of funeral director Watkins & Bros
(b) Address 1729 Lydia

19. (a) 8-14-44 (Date received local registrar) (b) N. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 9
year 1944 hour 11:45 minute P. M.

21. I hereby certify that I attended the deceased from Deputy Coroner, 19...;
that I last saw h... alive on ..., 19...;
and that death occurred on the date and hour stated above.

Immediate cause of death Acc Fall
Fracture of Cervical Spine

Due to

Due to

Other conditions 1860 5
(Include pregnancy within 3 months of death) 10

Major findings:
Of operations

Of autopsy Yes

Duration

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) Acc

(b) Date of occurrence 8-8-44

(c) Where did injury occur? K. C. (City or town) Jackson (County) Mo (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? In home (Specify type of place)

While at work? No (e) Means of injury Acc Fall

23. Signature L. P. Richardson (M.D. or other)

Address 1832 Vine Date signed 8/11/44

3 1

(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. 3994

P. O. Address 2503 Highlan

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

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

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STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3336

1. PLACE OF DEATH:
(a) County: Jackson
(b) City or town: K. C.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Gen. Hosp. # 2
(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

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits write "RURAL")
(d) Street No.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME: Hoyt L. Allen
3. (b) If veteran, name war
3. (c) Social Security No. 495-07-6948

4. Sex
5. Color or race
6. (a) Single, widowed, married, divorced
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)

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

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

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

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

16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day year hour minute M.
21. I hereby certify that I attended the deceased from , 19, to , 19; that I last saw h alive on , 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
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?
While at work? (Specify type of place) (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

26721