V. S. No. 2
00M—2-43
Rev. 5-17-39
1 X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 6 1945

Registration District No. 149

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 940

Primary Registration District No. 1002

Registrar's No. 328

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: 2 mos. 16 days (Specify whether years, months or days)

In this community: since 1890 0

2. USUAL RESIDENCE OF DECEASED:

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

(c) City or town: Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No.: 3516 Paseo 8
(If rural, give location)

(e) Citizen of foreign country? no. 0 (Yes or No)

If yes, name country: x

3. (a) PRINT FULL NAME: Jennie Allen

3. (b) If veteran, name war: no.

3. (c) Social Security No.: no.

4. Sex: Female 1

5. Color or race: White

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

6. (b) Name of husband or wife: Henry Allen

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

7. Birth date of deceased: June (Month) 20 (Day) 1855 (Year)

8. AGE: Years 89 Months 6 Days ~~30~~ 29 If less than one day hr. min.

9. Birthplace: Indiana (City, town, or county) 1 (State or foreign country)

10. Usual occupation: at home,

11. Industry or business: no.

MOTHER FATHER

12. Name: Robert Wilbur Coles,

13. Birthplace: unknown, 9 (City, town, or county) (State or foreign country)

14. Maiden name: Annie E.

15. Birthplace: Mrs. J. Unknown, Colo., 9 (City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. James Colfax Coles,

(b) Address: Everton, Missouri,

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1-23-45 (Month) (Day) (Year)

(c) Place: burial or cremation: Mt. Washington Cemetery

18. (a) Signature of funeral director: Stine & McClure,

(b) Address: 3235 Gillham Plaza, K. C., Mo.

19. (a) 1-22-45 (Date received local registrar) (b) D. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 19 year 1945 hour 11 minute 5 A. M.

21. I hereby certify that I attended the deceased from November 3, 1944 to January 19, 1945, that I last saw her alive on January 19, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of breast — Duration

Due to:

Due to: 50

Other conditions (Include pregnancy within 3 months of death):

Major findings:
Of operations:

Of autopsy: None

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: 0

23. Signature: A. E. Usher (M. D. or other) MD

Address: Med. Dir. Gen'l Hosp. Date signed: 1-20-45

(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. 1415

P. O. Address K. C. M

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.