

FILED MAR 7 1945
149

Registration District No.

Primary Registration District No.

1002

877

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Transas

(c) Name of hospital or institution: General Hospital O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Day (Specify whether years, months or days) lifetime

3. (a) PRINT FULL NAME Elizabeth 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 Married

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

6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased Sept 17 1885
(Month) (Day) (Year)

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

59 5 5 hr. min.

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

10. Usual occupation Home

11. Industry or business

12. Name John Bethel

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

14. Maiden name Do not know

15. Birthplace Do not know (City, town, or county) (State or foreign country)

16. (a) Informant Joseph Wardell

(b) Address 607 E 8th St

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 24 45 (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director Pasantino Bros

(b) Address 12 E mo

19. (a) 2-23-45 (Date received local registrar) (b) D. E. Brown (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Jackson

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

(d) Street No. 616 E 8th St (If rural, give location)

(e) Citizen of foreign country? (Yes or No) 0
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 22 year 1945 hour 11 minute A. M.

21. I hereby certify that I attended the deceased from Jan 19 to Feb 19 that I last saw h. alive and that death occurred on the date and hour stated above.

Immediate cause of death Tubercular pneumonia (right & left)

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) 108

Major findings: Of operations History & Inspection

Of autopsy not

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)

(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 Janice Walker (M. D. or other) Janice

Address 114 E 4th St Date signed 2-22-45

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

MOTHER FATHER

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..... *Francis Walter*

Licensed Embalmer No. *2744*

P. O. Address..... *1467me*

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.