

FILED JUL 21 1945  
Registration District No. 150

Primary Registration District No. 5573

State File No. \_\_\_\_\_  
Registrar's No. 73

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

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Rural Prairie, Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Jackson Co. Home for aged Neopols  
(If not in hospital or institution, write street number & location)  
(d) Length of stay: In hospital or institution 2 weeks 4 days  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Mary Allen  
(b) If veteran, name war \_\_\_\_\_  
(c) Social Security No. \_\_\_\_\_  
4. Sex Female 5. Color or race Neapol  
6. (a) Single, widowed, married, divorced 9  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: unknown  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
about 63 1 11 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation: Domestic

11. Industry or business: \_\_\_\_\_

12. Name: \_\_\_\_\_  
13. Birthplace: Mo 9  
(City, town, or county) (State or foreign country)

14. Maiden name: \_\_\_\_\_  
15. Birthplace: Mo 9  
(City, town, or county) (State or foreign country)

16. (a) Informant: Jackson County Home  
(b) Address: Independence, Route 14

17. (a) RE DENIAL COLLEGE (b) Date thereof: 6-7-1945  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation: Anatomical H.C. Dist College

18. (a) Signature of funeral director: Brady Brown  
(b) Address: 1708 Troy St. E. Mo.

19. (a) June 6-45 (b) W. M. Schuch  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO (b) County Jackson 48  
(c) City or town R.C. (If outside city or town limits, write "RURAL") 3  
(d) Street No. \_\_\_\_\_ (If rural, give location) 0  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) 1  
If yes, name country \_\_\_\_\_

20. DATE OF DEATH: Month 6 day 5th  
year 45 hour 9 minute 15A M.  
21. I hereby certify that I attended the deceased from May 17th 1945 to June 5 1945  
that I last saw her alive on June 5 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death: Circulatory Failure  
Due to: Myocardial Insufficiency

Due to: \_\_\_\_\_  
Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations: \_\_\_\_\_  
Of autopsy: 92h

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: Samuel H. Griffin (M. D. or other) 7/9  
Address: Independence, Mo Date signed: 6/15/45

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

**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 \_\_\_\_\_

working under my personal supervision.

Registered Apprentice No. \_\_\_\_\_

Signed \_\_\_\_\_

Licensed Embalmer No. 1274

P. O. Address Kansas City 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.**