

State File No. \_\_\_\_\_

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 111

**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:  
1843 EAST 76th STREET  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
 In this community 30 yrs years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State MISSOURI (b) County JACKSON  
 (c) City or town KANSAS CITY  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 1843 EAST 76th STREET  
 (If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** FRANK SHEPPARD ALLISON  
 3. (b) If veteran, name war no  
 3. (c) Social Security No. 486-05-5374

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month JAN day 9  
 year 1947 hour 5 minute 00A M.  
 21. I hereby certify that I attended the deceased from Jan 5  
1947 to Jan 9, 1947  
 that I last saw him alive on Jan 9, 1947  
 and that death occurred on the date and hour stated above.

4. Sex MALE 5. Color or race WHITE  
 6. (a) Single, widowed, married, divorced MARRIED  
 6. (b) Name of husband or wife MRS. EDNA M. ALLISON  
 6. (c) Age of husband or wife if alive 62 years  
 7. Birth date of deceased AUGUST 29 1885  
 (Month) (Day) (Year)

Immediate cause of death Coronary Thrombosis  
 Due to Hypertension  
 Due to \_\_\_\_\_  
 Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
 Major findings: Of operations 9/10  
 Of autopsy \_\_\_\_\_

**8. AGE:**

Years	Months	Days	If less than one day
<u>61</u>	<u>4</u>	<u>10</u>	hr. _____ min. _____

**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? \_\_\_\_\_

9. Birthplace BAITIMORE MARYLAND  
 (City, town, or county) (State or foreign country)

10. Usual occupation PRESIDENT

11. Industry or business ALLISON DISTRIBUTING Co.

12. Name JAMES S. Allison

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

14. Maiden name MARGARETTA BEAMS

15. Birthplace BAITIMORE MARYLAND  
 (City, town, or county) (State or foreign country)

16. (a) Informant MRS. EDNA M. Allison

(b) Address 1843 EAST 76th STREET

17. (a) Burial (b) Date thereof JAN. 11, 1947  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Newcomer's Vault

18. (a) Signature of funeral director D. J. Newcomer

(b) Address 1401 Birch Creek Blvd

19. (a) 1-10-47 (b) Geraldine Holmia  
 (Date received local registrar) (Registrar's signature)

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 0

23. Signature J. J. Lane (M. D. or other)

Address 1010 Professional Date signed 1-9-47

MOTHER FATHER

**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed Ernie M. Colburn

Licensed Embalmer No. 3506 //

P. O. Address KC Mo.

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

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

Registration District No. *149*

Primary Registration District No. *1002*

Registrar's No. *111*

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:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME *Frank Sheppard Allison*  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

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 \_\_\_\_\_

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 \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) *Removal* (Burial, cremation, or removal) (b) Date thereof *6-2-47*  
(Month) (Day) (Year)

(c) Place: burial or cremation *Baltimore Maryland*

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) *1-10-47* (Date received local registrar) (b) *Seraldine Holmes* (Registrar's signature)

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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *June* year *1947* hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

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

MOTHER FATHER

S-950