

BUREAU OF THE CENSUS
FILED APR 23 1947

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1620

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:
2017 College Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 49 Yrs.
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Ellen 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 Widowed
6. (b) Name of husband or wife Thomas Allen 6. (c) Age of husband or wife if alive years
7. Birth date of deceased July 11 1861
(Month) (Day) (Year)

8. AGE: Years 85 Months 38 Days 25 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business
12. Name Unknown
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant R. H. Allen
(b) Address 2007 College Ave.

17. (a) Burial (b) Date thereof 4/9/1947
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Washington

18. (a) Signature of funeral director Earp & Sons
(b) Address 4139 E. 15th. St

19. (a) 4-9-47 (b) R. H. Allen
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limit write "RURAL")
(d) Street No. 2017 College
(If rural, give location)
(e) If foreign born, how long in U. S. A.? No years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 6
year 1947 hour 5 minute 45 P.M.
21. I hereby certify that I attended the deceased from July
1940 to April 6, 1947
that I last saw her alive on April 6, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive pneumonia
Due to Myocardial Degeneration
Duration 3 days

Other conditions (Include pregnancy within 3 months of death)
Due to g. d.

Major findings: Of operations g. d.
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 2
23. Signature L. W. Higgins (M.D. or other) D.O.
Address Bushnell MO Date signed 4/9/47

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.....

.....
working under my personal supervision.

Registered Apprentice No.

Signed.....

Licensed Embalmer No. 2955

P. O. Address W. E. SMO

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, above space should be left blank.