

FEDERAL SECURITY AGENCY

National Office of Vital Statistics

FILED APR 12 1948

Registration District No. 149

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 8680

Registrar's No. 1296

48
3
8

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

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: Northeast Osteopathic Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days
In this community 5 days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME ALLEN RAY ELI

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased March 17 1948
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 5 If less than one day _____ hr. _____ min.

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

10. Usual occupation infant

11. Industry or business _____

12. Name Cecil A Eli

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

14. Maiden name Florence W Mawby

15. Birthplace Kansas City Mo
(City, town, or county) (State or foreign country)

16. (a) Informant C.A. Eli

(b) Address 39th & Ditzler

17. (a) Burial (b) Date thereof 3-24-1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director C.H. Blackman & Son, Inc

(b) Address 2825 Independence Blvd.

19. (a) 3-24-48 (b) Thelma Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City "Rural"
(If outside city or town limits, write "RURAL")
(d) Street No. 39th & Ditzler
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 23
year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from 3
17 1948, to 3-23 1948
that I last saw him alive on 3-23 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory failure

Due to Premature birth
180 days

Due to unknown

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

Major findings: 159
Of operations _____

Of autopsy _____

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 No

23. Signature Earl Van Jones (M.D. or other) Do

Address 100 1/2 S. Ashmun Date signed 3-24-48

Duration _____
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.....

Licensed Embalmer No.....

P. O. Address.....

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.