

FILED APR 6 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8314
State File No. 1079

BIRTH NO.		REG. DIST. NO. 149	PRIMARY REG. DIST. NO. 1002	Registrar's No. 1079
1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY JACKSON		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY		
c. LENGTH OF STAY (In this place) 8 MONTHS		d. STREET ADDRESS (If rural, give location) 5540 GARFIELD AVENUE		
d. FULL NAME OF HOSPITAL OR INSTITUTION		5540 GARFIELD AVENUE		
3. NAME OF DECEASED (Type or Print) a. (First) ALLIE b. (Middle) GREEN c. (Last) CLAUNCH		4. DATE OF DEATH (Month) (Day) (Year) MAR. 8-1949		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH JUNE-11-1922	
9. AGE (In years last birthday) 76 YEARS		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) HAMILTON, TEXAS
13a. FATHER'S NAME DR. J. P. VALLIANT		13b. MOTHER'S MAIDEN NAME ALLIE BRANDON		14. NAME OF HUSBAND OR WIFE WILLIAM B. CLAUNCH
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME ALLIE D. LOVEBAY ADDRESS 5540 GARFIELD AVE. KANSAS CITY, MO.
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bullet Wound Head ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. E 976		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) Suicide		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) at home		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Kansas City Jackson MO
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 3-8-49 11:50 P. M.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Self-inflicted
22. I hereby certify that I attended the deceased from _____, 19____ to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 1:50 P. M., from the causes and on the date stated above.				
23a. SIGNATURE Hugh H. Owens		23b. ADDRESS 1034 Oakto Bldg		23c. DATE SIGNED 3-9-49
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		24b. DATE MAR. 9-1949		24c. NAME OF CEMETERY OR CREMATORY HARRIS
24d. LOCATION (City, town, or county) (State) HARRIS, TEXAS		25. FUNERAL DIRECTOR'S SIGNATURE D. H. Newcomer ADDRESS 1401 BRUSH CREEK BLVD KANSAS CITY MISSOURI		
DATE REC'D BY LOCAL REG. 3-9-49		REGISTRAR'S SIGNATURE Seraldine Holmes		

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

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

DOYLE L. DANIEL

Student Embalmer No. 278

working under my personal supervision.

Student Doyle L. Daniel

Student Embalmer

Signed

Edward M. Storey

Licensed Embalmer No. 4452

P. O. Address K.C. 4 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.