

FILED JUL 28 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23777

BIRTH NO. _____ REG. DIST. NO. 146 PRIMARY REG. DIST. NO. 5568 Registrar's No. 221

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	c. LENGTH OF STAY (In this place) 25 yrs	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City Rural (Blue)	
d. FULL NAME OF HOSPITAL OR INSTITUTION 8730 Wilson Rd.,		d. STREET ADDRESS (If rural, give location) 8730 Wilson Rd.,	

3. NAME OF DECEASED (Type or Print) a. (First) Noah	b. (Middle) E	c. (Last) Allman	4. DATE OF DEATH (Month) (Day) (Year) 7/19/49
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5. SEX Male	6. COLOR OR RACE Wh	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 3/28/1869	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months Days	IF UNDER 1 HR. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Harrison Co., Mo.	12. CITIZEN OF WHAT COUNTRY? US
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13a. FATHER'S NAME Unk	13b. MOTHER'S MAIDEN NAME Unk	14. NAME OF HUSBAND OR WIFE Edna Pearl Skinner Allman
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) no	17. INFORMANT'S SIGNATURE OR NAME Carl W. Allman	ADDRESS 2320 So Early, K C Kans
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Sclerosis		
	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.		4201	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Deputy Coronar	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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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 _____ m., from the causes and on the date stated above.

23a. SIGNATURE DePiero MD	23b. ADDRESS 2800 Main	23c. DATE SIGNED 7/20/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7/20/49	24c. NAME OF CEMETERY OR CREMATORY Floral Hills	24d. LOCATION (City, town, or county) (State) Kansas City, Mo.
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DATE REC'D BY LOCAL REG. July 20-1949	REGISTRAR'S SIGNATURE James A. Sears	25. FUNERAL DIRECTOR'S SIGNATURE John P. Sheil	ADDRESS Kansas City, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

JUL 26 RECD

AUG 3 1949

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

John P. Shind

Licensed Embalmer No. 3625

P. O. Address R. C. [unclear]

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.