

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

24604  
3416

State File No. \_\_\_\_\_  
Registrar's No. \_\_\_\_\_

FILED JUL 28 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

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 OR TOWN **Kansas City** c. LENGTH OF STAY (in this place) \_\_\_\_\_

c. CITY OR TOWN **Kansas City** d. Is Residence within limits of a city or incorporated town? Yes  No

d. FULL NAME OF HOSPITAL OR INSTITUTION **4009 Highland Avenue** e. STREET ADDRESS (If rural, give location) **4009 Highland Avenue** **3648**

3. NAME OF DECEASED a. (First) **Mabel** b. (Middle) **Clair** c. (Last) **ALLISON** 4. DATE OF DEATH (Month) (Day) (Year) **July 7, 1953**

5. SEX **Female** 6. COLOR OR RACE **White** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **widowed 2** 8. DATE OF BIRTH **7-26-78** 9. AGE (in years last birthday) **74** IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **At home** 10b. KIND OF BUSINESS OR INDUSTRY \_\_\_\_\_ 11. BIRTHPLACE (City and State or Foreign Country) **Centerville, Iowa /** 12. CITIZEN OF WHAT COUNTRY? **USA**

13a. FATHER'S NAME **Julius A. Connor** 13b. MOTHER'S MAIDEN NAME **Sarah V. Lee** 14. NAME OF HUSBAND OR WIFE **Clarence Allison**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **no** (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. **none** 17. INFORMANT'S SIGNATURE OR NAME **Mrs. Cecile Siebers** ADDRESS **4009 Highland, KC, Mo.**

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) **Myocardial Infarction**  
ANTECEDENT CAUSES 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. **4200**

19a. DATE OF OPERATION \_\_\_\_\_ 19b. MAJOR FINDINGS OF OPERATION \_\_\_\_\_ 20. AUTOPSY? YES  NO

21a. ACCIDENT (Specify) **Natural** 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) \_\_\_\_\_ 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. 21e. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK  21f. HOW DID INJURY OCCUR? \_\_\_\_\_

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 **High H. Owens** (Degree or title) 23b. ADDRESS **1034 Pinalto Bldg.** 23c. DATE SIGNED **7-9-53**

24a. BURIAL, CREMATION, REMOVAL (Specify) **Removal** 24b. DATE **7-9-53** 24c. NAME OF CEMETERY OR CREMATORY **OAKLAND CEMETERY** 24d. LOCATION (City, town, or county) (State) **Centerville, Iowa**

DATE REC'D BY LOCAL REG. **7-9-53** REGISTRAR'S SIGNATURE **Beraldine Smith** 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS **Melody-McGilley-Eylar, Kansas City, Mo.**

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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Don E. Heck*

Licensed Embalmer No. *4063*

P. O. Address *Kansas City*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.