

FILED FEB 8 - 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

1054

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 290

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b>		b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kansas City</b>		c. LENGTH OF STAY (in this place) <b>28 yrs.</b>		c. CITY OR TOWN <b>Kansas City</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <b>331 S. Van Brunt</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>William</b>		b. (Middle) <b>Henry</b>		c. (Last) <b>Allen</b>	
4. DATE OF DEATH (Month) (Day) (Year) <b>Jan. 21, 1955</b>		5. SEX <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female			
6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>Dec. 29, 1885</b>	
9. AGE (In years last birthday) <b>69</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Oak Grove, Ark.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		13a. FATHER'S NAME <b>James M. Allen</b>		13b. MOTHER'S MAIDEN NAME <b>Emeline Minnick</b>	
14. NAME OF HUSBAND OR WIFE <b>Grace I. Allen</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>487-07-5476</b>	
17. INFORMANT'S SIGNATURE OR NAME <b>Grace I. Allen</b>		ADDRESS <b>331 S. Van Brunt</b>			

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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>15 days</b>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arterio Sclerosis</b>			
		DUE TO (c) <b>-</b>			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<b>331</b>	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 1/7, 1955, to 1/21, 1955, that I last saw the deceased alive on 1/21, 1955, and that death occurred at 12:15 p.m., from the causes and on the date stated above.

23a. SIGNATURE <b>R.A. Williams</b>		(Degree or title) <b>MD</b>		23b. ADDRESS <b>5400 St. John Kansas City</b>	
23c. DATE SIGNED <b>1/22, '55</b>		24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>Jan. 24, 1955</b>	
24c. NAME OF CEMETERY OR CREMATORY <b>Mt. Washington Ceme</b>		24d. LOCATION (City, town, or county) (State) <b>Kansas City, Missouri</b>		DATE REC'D BY LOCAL REG. <b>1-22-55</b>	
REGISTRAR'S SIGNATURE <b>Neve Marshall</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Earp &amp; Sons 4139 Truman Rd. K.C. Mo</b>			

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

*W. J. Johnson*  
*3-6-12. 9011*

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.....  
Licensed Embalmer No. *295*  
P. O. Address... *H. C. M.*

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.