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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25316

State File No.
884

FILED AUG 22 1955

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No.

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		c. LENGTH OF STAY (In this place) <u>17 yrs</u>	c. CITY OR TOWN <u>St. Joseph</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>209 E. Kansas Ave.</u>		e. STREET ADDRESS (If rural, give location) <u>209 E. Kansas Ave.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Willis</u> b. (Middle) <u>Edward</u> c. (Last) <u>Allen</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 17, 1955</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	
8. DATE OF BIRTH <u>March 28, 1879</u>		9. AGE (In years last birthday) <u>76</u>		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Section Foreman C. B. & Q. R. R.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Phillipsburg, Kansas</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Winfield Scott Allen</u>		13b. MOTHER'S MAIDEN NAME <u>Margaret Rhoades</u>	
14. NAME OF HUSBAND OR WIFE <u>Sarah E. Allen</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>707-09-6145</u>	

17. INFORMANT'S SIGNATURE OR NAME <u>Sarah E. Allen</u>		ADDRESS <u>209 E. Kansas Av.</u>	
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Heart Failure - acute</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> ANTECEDENT CAUSES DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Senility</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		St. Joseph, Mo.	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		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)	
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?	

22. I hereby certify that I attended the deceased from 3-6, 1954, to 8-17, 1955, that I last saw the deceased alive on 8-17-55, 1955, and that death occurred at 6:55 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Dr. R. Harris, D.O.</u>		23b. ADDRESS <u>103 W. Mo. Ave. - City</u>		23c. DATE SIGNED <u>8-18-55</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Aug. 20, 1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Bolckow Cemetery</u>	
24d. LOCATION (City, town, or county) (State) <u>Bolckow, Mo.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Clark</u>		ADDRESS <u>St. Joseph, Mo.</u>	

DATE REC'D BY LOCAL REG. <u>Aug 19, 1955</u>		REGISTRAR'S SIGNATURE <u>Ruth M. Allison</u> <u>485</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Clark</u>	
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(Licensed Embalmer's Statement on Reverse Side)

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 *E. A. Clark*.....

Licensed Embalmer No... 412

P. O. Address *St. Louis*

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.