

FILED FEB 7 1956

# STANDARD CERTIFICATE OF DEATH

State File No. **3448**

BIRTH NO.		REG. DIST. NO. <b>324</b>		PRIMARY REG. DIST. NO. <b>3072</b>		Registrar's No. <b>21</b>	
1. PLACE OF DEATH a. COUNTY <b>SALINE</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY <b>SALINE</b>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>MARSHALL</b>		c. LENGTH OF STAY (in this place) <b>36 HRS.</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>SALT POND TWP.</b>		p 970	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>FITZGIBBON'S HOSPITAL</b>				d. STREET ADDRESS (If rural, give location) <b>9 MILE NORTH OF SWEET SPRINGS</b>			
3. NAME OF DECEASED (Type or Print) <b>EDMUND FRANKLIN ALLEN</b>		a. (First)		b. (Middle)		c. (Last)	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>FEBRUARY 4, 1890</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMING</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>SALINE COUNTY, Mo</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13a. FATHER'S NAME <b>ANDREW J. ALLEN</b>		13b. MOTHER'S MAIDEN NAME <b>SARAH A. VENEABLE</b>		14. NAME OF HUSBAND OR WIFE <b>ALMA AGNES KUECK</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>490-42-9371</b>		17. INFORMANT'S SIGNATURE OR NAME <b>MRS ALMA ALLEN-Sweet Springs, Mo</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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Acute Pulmonary Embolism</b> INTERVAL BETWEEN ONSET AND DEATH <b>20 min</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Cardiac Arricular Fibrillation</b> <b>48 hrs.</b> DUE TO (c) <b>Myocardial Infarction</b> <b>48 hrs.</b> 2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Cerebral Thrombosis</b> <b>5 days</b>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>4201</b>				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) (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 <b>1/21</b> , 1956, to <b>1/26</b> , 1956, that I last saw the deceased alive on <b>1/26</b> , 1956, and that death occurred at <b>3:30 PM</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>Charles A. Miller, M.D.</b>				23b. ADDRESS <b>Sweet Springs, Mo</b>		23c. DATE SIGNED <b>1/27/56</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>JANUARY 29, 1956</b>		24c. NAME OF CEMETERY OR CREMATORY <b>FAIRVIEW Cem.</b>		24d. LOCATION (City, town, or county) (State) <b>Sweet Springs, Mo</b>	
DATE REC'D BY LOCAL REG. <b>Jan 29-56</b>		REGISTRAR'S SIGNATURE <b>Cecil G. Reah</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>L. F. Parker</b>		ADDRESS <b>Sweet Springs, Mo</b>	

(Licensed Embalmer's Statement on Reverse Side)

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

*L. F. Parker*

Licensed Embalmer No.

*3840*

P. O. Address

*Sweet Springs*

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.