

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **4937**
Registrar's No. **543**

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. CITY OR TOWN <u>Kansas City</u>	d. Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) <u>50 yrs.</u>		e. STREET ADDRESS (If rural, give location) <u>900 E. 9th Street</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>900 E. 9th St.</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>JOSEPH</u>	b. (Middle) <u>MCALLISTER</u>	c. (Last) <u>MCALLISTER</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Feb - 3 - 1956</u>
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5. SEX <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, 2 WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <u>March - 26 - 1880</u>	9. AGE (In years last birthday) <u>75</u>	IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u>	IF UNDER 1 HR. Hours <u>-</u> Min. <u>-</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Teacher</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Transportation Eggs</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Lancaster, Wisconsin</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			

13a. FATHER'S NAME <u>John McAllister</u>	13b. MOTHER'S MAIDEN NAME <u>Josephine Roesch</u>	14. NAME OF HUSBAND OR WIFE <u>Tessie McAllister</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>487-03-7528</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Ms. Luma Hawkins</u>	ADDRESS <u>401 N. Lawn</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary heart disease</u>	DUE TO (b) <u>Atherosclerosis</u>		420
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (c) <u>Pulmonary fibrosis</u>		
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

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) <u>Kansas City Jackson Mo</u>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	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 Jan, 1955, to Feb 3, 1956, that I last saw the deceased alive on Feb. 3, 1956, and that death occurred at 10:00 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>F. L. Shoreman M.D.</u>	23b. ADDRESS <u>4606 St. John Ave</u>	23c. DATE SIGNED <u>2-4-56</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>2-6-56</u>	24c. NAME OF CEMETERY OR CREMATORY <u>W. Washington Cem</u>	24d. LOCATION (City, town, or county) (State) <u>K.C. Missouri</u>
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DATE REC'D BY LOCAL REG. <u>2-6-56</u>	REGISTRAR'S SIGNATURE <u>Neva Marshall</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>C.H. Blackman</u>	ADDRESS <u>San Jose</u>
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(Licensed Embalmer's Statement on Reverse Side)

K. C. Mo.

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

No. 300
10.48

FILED FEB 17 1956

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 *W.C. Quinn*.....

Licensed Embalmer No. *487*.....

P. O. Address *N.C. 271*.....

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.