

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13165

STATE FILE NUMBER

FILED MAY 1 - 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1762

Health,
Welfare
Public
Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Max S. Allen

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 (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Lake Tapawingo Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Grosse Nursing Home Length of stay in lb 5 1/2 mo.		d. STREET ADDRESS 7000 O (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MURIEL Middle _____ Last HAYWARD			4. DATE OF DEATH Month April Day 16th Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 29, 1888
9. AGE (In years last birthday) 68		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 country) Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles T. Davis	
14. MOTHER'S MAIDEN NAME Mary Longborn		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 486-09-9173		17. INFORMANT Mrs. Louise H. Suttles, Lake Tapawingo, Mo.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis - hemiplegia DUE TO (b) Cerebral arteriosclerosis DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 9 mos. 5 yrs. 332 X
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour _____ Month _____ Day _____ a. m. _____ p. m.	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>July 15, 1956</u> to <u>April 15, 1957</u> and last saw her <u>alive</u> on <u>April 3, 1957</u> Death occurred at <u>5:00 a. m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Max S. Allen, M.D.		22b. ADDRESS K. H. Medical Center, K. C. Kans.	
22c. DATE SIGNED 4-16-57		23. LOCATION (City, town, or county) (State) Kansas City, Missouri	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 4-17-57	
23c. NAME OF CEMETERY OR CREMATORY Elmwood Crematory		23d. LOCATION (City, town, or county) (State) Kansas City, Missouri	
24. FUNERAL DIRECTOR ADDRESS FREEMAN MORTUARY, Kansas City, Mo.		25. DATE RECD. BY LOCAL REG. 4-16-57	
26. REGISTRAR'S SIGNATURE Neva Minshall			

(Licensed Embalmer's Statement on Reverse Side)

DR. CHRISTENSON

UNIVERSITY OF KANSAS

MEDICAL CENTER

BEFORE 11:00 P.M.

TUES.



we-0306

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 *J. H. Freeman*

Licensed Embalmer No. 295

P. O. Address H. O. -

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.