

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-018311
STATE FILE NUMBER

FILED JUN 8 1959 Registration District No. 176-5654 Primary Registration District No. 5-654 Registrar's No. 8

1. PLACE OF DEATH a. COUNTY Lawrence		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Lawrence	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Miller		c. CITY OR TOWN Miller	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Residence		d. STREET ADDRESS (If outside, give location) P.R.	
Length of stay in lb Native		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last Jack Allen			4. DATE OF DEATH Month Day Year 5-17-1959		
5. SEX Male	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 3-5-1883	9. AGE (In years last birthday) 76	10. F UNDER 1 YEAR Months Days Hours Min. 2 12
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Lawrence Co. Mo	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Jim Allen		13b. MOTHER'S MAIDEN NAME Mary Allen	
14. NAME OF HUSBAND OR WIFE Deceased		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no. none		16. SOCIAL SECURITY NO. 499-24-5560	
17. INFORMANT Mrs. Vera McGehee		Address 3031 Pearl		City State Joplin Mo.	

18. CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Organic heart disease DUE TO (b) Valvular complications DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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, Year 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 7:04 1-9 to 5-17-59 and last saw her alive on 5-15-59 Death occurred at 8 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE W. S. Bunsley M.D.		22b. ADDRESS 7711 1/2 St Mo		22c. DATE SIGNED 6-3-59	

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-19-1959		23c. NAME OF CEMETERY OR CREMATORY St. Ignace	
23d. LOCATION (City, town, or county) N.E. of Miller Mo		23e. DATE RECD. BY LOCAL REG. 6-8-59		23f. REGISTRAR'S SIGNATURE Thomas C. Davidson	
24. FUNERAL DIRECTOR Morris Feiman			ADDRESS Miller Mo.		

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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1-57
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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. R. Leiman*

Licensed Embalmer No. *3297*.....

P. O. Address *Miller*.....

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.