

8

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-021190

FILED JUL 13 1959

STATE FILE NUMBER 3053

Registration District No. 149 Primary Registration District No. 1002

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY Jackson   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Missouri b. COUNTY Jackson |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN Kansas City             |  | c. CITY OR TOWN Kansas City  |  |
| Inside Limits: Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>           |  | Inside Limits: Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |  |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION 3537 Main St. |  | d. STREET ADDRESS 3806 Roanoke Rd.   |  |
| Length of stay in lb. 9 yrs.   |  | Reside on Farm: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |  |

|   |  |  |   |  |  |  |
|---|--|--|---|--|--|--|
| 3. NAME OF DECEASED (Type or print)<br>First James Middle A. Last Bahen |  |  | 4. DATE OF DEATH<br>Month June Day 23 Year 1959 |  |  |  |
|---|--|--|---|--|--|--|

|             |                        |   |                                |                                    |                                |                               |
|-------------|------------------------|---|--------------------------------|------------------------------------|--------------------------------|-------------------------------|
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 28, 1883 | 9. AGE (In years last birthday) 76 | IF UNDER 1 YEAR<br>Months Days | IF UNDER 24 HRS<br>Hours Min. |
|-------------|------------------------|---|--------------------------------|------------------------------------|--------------------------------|-------------------------------|

|  |                                   |  |                                  |
|--|-----------------------------------|--|----------------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, except retired) Supt. Power Light Co. | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) Rock Island, Illinois | 12. CITIZEN OF WHAT COUNTRY? USA |
|--|-----------------------------------|--|----------------------------------|

|                                   |  |  |
|-----------------------------------|--|--|
| 13a. FATHER'S NAME James J. Bahen | 13b. MOTHER'S MAIDEN NAME Ellen F. O'Brien | 14. NAME OF HUSBAND OR WIFE Minnie Bahen |
|-----------------------------------|--|--|

|   |                                     |   |
|---|-------------------------------------|---|
| 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. 331-07-0837 | 17. INFORMANT Mrs. C. V. O'Connell, 3806 Roanoke Rd. Mo. Address K.C. |
|---|-------------------------------------|---|

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple Sclerosis   |  | INTERVAL BETWEEN ONSET AND DEATH<br>Autism<br>years |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) General Arteriosclerosis<br>DUE TO (c) - |  |   |

|  |  |  |
|--|--|--|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) None Known |  | 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<br>Hour Month, Day, Year<br>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 Death occurred at 11:45 AM on 2/14/53 | last saw him alive on 6/23/59 |
|--|-------------------------------|

|  |                           |                          |
|--|---------------------------|--------------------------|
| 22a. SIGNATURE William Bayne Allen (Degree or title) | 22b. ADDRESS 3806 Parkway | 22c. DATE SIGNED 6/23/59 |
|--|---------------------------|--------------------------|

|   |                   |                                     |   |
|---|-------------------|-------------------------------------|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 6-24-59 | 23c. NAME OF CEMETERY AND CREMATORY | 23d. LOCATION (City, town, or county) Rock Island, Illinois (State) |
|---|-------------------|-------------------------------------|---|

|   |                                      |   |
|---|--------------------------------------|---|
| 24. FUNERAL DIRECTOR Mellody-McGilley-Eylar - 20 W. Linwood K.C.Mo. | 25. DATE RECD. BY LOCAL REG. 6-23-59 | 26. REGISTRAR'S SIGNATURE Vera Marshall |
|---|--------------------------------------|---|

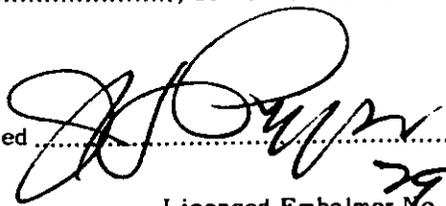
William Bayne Allen  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

Wasa. 13.  
46 x 0 Q. P. 77  
after 1:15

**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  .....  
Licensed Embalmer No. 7999 .....  
P. O. Address ..... (K)

**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.