

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-021244

FILED JUN 24 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2789

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, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Luke Hosp</u>		Length of stay in lb <u>18 yrs</u>	d. STREET ADDRESS (If outside, give location) <u>4544 Park</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>ALLENE M. BUCHANAN</u>			4. DATE OF DEATH Month Day Year <u>6/6/59</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-21-13</u>		9. AGE (In years last birthday) <u>46</u> IF UNDER 1 YEAR Months Days <u>3 13</u> IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Ada, Oklahoma</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>William A Cope</u>			13b. MOTHER'S MAIDEN NAME <u>Cora Dodd</u>			14. NAME OF HUSBAND OR WIFE <u>Lloyd Buchanan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Lloyd Buchanan 4544 Park Ave</u>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u>			<u>6 weeks</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Rheumatic Heart Disease @ post</u>		<u>5 years</u>		
	DUE TO (c) <u>Communicatory Surgery for Mitral Stenosis</u>				
		<u>Valvular Disease (1953)</u>			
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 checked="" type="checkbox"/> NO <input type="checkbox"/>
					<u>410X</u>

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 WORK <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>January 1944</u> to <u>June 6, 1959</u> and last saw her/him alive on <u>June 6, 1959</u> . Death occurred at <u>Hopkins City, Mo. 2:30 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Arnold V. Arns Md.</u>			22b. ADDRESS <u>4635 Wyandotte St. City Mo. 64615</u>		22c. DATE SIGNED <u>6/6/59</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>6-9-59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City Mo.</u>	
24. FUNERAL DIRECTOR <u>W W Newcomer's Son Mo.</u>			ADDRESS <u>K. C.</u>		25. DATE RECD. BY LOCAL REG. <u>6-8-59</u>		26. REGISTRAR'S SIGNATURE <u>Arvid Marshall</u>

with, welfare, public service

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Arnold V. Arns

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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 *Tom Lawler* .....

Licensed Embalmer No. *4915* .....  
P. O. Address *K.C. Mo* .....

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.