

JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 3 2 3 2

FILED VS. DEC 29 1959 4

STATE FILE NUMBER

INDEXED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 122

1. PLACE OF DEATH a. COUNTY ATCHISON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY HOLT	
b. CITY (If outside corporate limits, give TOWNSHIP only) FAIRFAX		c. CITY OR TOWN MOUND CITY	
Length of stay in 1b 2 Hours		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Community Hosp.		d. STREET ADDRESS (If outside, give location) MOUND CITY	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First ADAM Middle DAVID Last ALLOWAY			4. DATE OF DEATH Month DEC. Day 21 Year 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 4-10-1875	9. AGE (last birthday) 84	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (City and state or country) FILLMORE, Mo.	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME JAMES ALLOWAY			
13b. MOTHER'S MAIDEN NAME MARY LANCE		14. NAME OF HUSBAND OR WIFE LYDIA M. ALLOWAY			
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. 488-14-4408		17. INFORMANT EVERETT ALLOWAY - OREGON, 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) Coronary Occlusion		Interval Between Onset and Death 4 hrs			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Coronary Thrombosis		Interval Between Onset and Death 4 hrs			
DUE TO (c) Arteriosclerotic heart disease		Interval Between Onset and Death unknown			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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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 _____ a.m. _____ p.m. Month, Day, Year _____			
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 July 1, 1952 , to Dec 21, 1959 and last saw him alive on Dec 21, 1959 Death occurred at 8:20 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE J. F. Sweeney (Degree or title) m - H.	22b. ADDRESS Oregon, Marion	22c. DATE SIGNED 12-21-59
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 12/23/1959	23c. NAME OF CEMETERY OR CREMATORY MOUNT HOPE Cemetery
24. FUNERAL DIRECTOR James H. Sweeney	25. DATE RECD. BY LOCAL REG. Dec 22, 1959	26. REGISTRAR'S SIGNATURE Thermin H. Schaefer

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 14 1980

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

James H. Crawford

Licensed Embalmer No. 4796

P. O. Address Mound Co

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.