

**FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

'59 0 4 3 6 8 2

FILED VS DEC 23 1959

STATE FILE NUMBER

Registration District No. 72 Primary Registration District No. 4134 Registrar's No. 219

1. PLACE OF DEATH a. COUNTY <b>Clay</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Clinton</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Smithville</b>	Length of stay in 1b <b>1 Week</b>	c. CITY OR TOWN <b>Trimble</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Smithville Community Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>None</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>Jerome</b> Last <b>Allen</b>			4. DATE OF DEATH Month <b>Dec.</b> Day <b>11,</b> Year <b>1959</b>	
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5. SEX <b>Ma</b>	6. COLOR OR RACE <b>Wh</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10-3-74</b>	9. AGE (last birthday) <b>85</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	11. BIRTHPLACE (City and state or country) <b>Platte Co, Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>John Allen</b>	13b. MOTHER'S MAIDEN NAME <b>Kate Callaway</b>	14. NAME OF HUSBAND OR WIFE <b>Florence Allen</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Mrs. Katherine Savage Topeka, Kansas</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>arteriosclerotic heart disease</b>	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>malnutrition</b>	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.)
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20c. TIME OF INJURY Hour <b>9:35 P.M.</b> 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 <b>Smithville, Mo.</b>	COUNTY <b>Clay</b>	STATE <b>Missouri</b>
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21. I attended the deceased from <b>Dec 1, 1959</b> to <b>Dec 11, 1959</b> and last saw <sup>her</sup> him alive on <b>Dec 11, 1959</b> Death occurred at <b>9:35 P.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <b>E. J. Wolfgram M.D.</b> (Degree or title)	22b. ADDRESS <b>Smithville Clinic Smithville, Mo.</b>	22c. DATE SIGNED <b>12-12-59</b> (State)
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12-13-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Paradise Cemetery</b>	23d. LOCATION (City, town, or county) <b>Clay County, Missouri</b>
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24. FUNERAL DIRECTOR <b>McComas Funeral Home</b>	ADDRESS <b>Smithville, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>12-13-59</b>	26. REGISTRAR'S SIGNATURE <b>Marquette Judgens</b>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Donald W. Hanks

Licensed Embalmer No. 4528

P. O. Address Smithville, 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.