

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-026695

FILED VS AUG 8 1960

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3842

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY Jackson	b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City		a. STATE Missouri b. COUNTY Jackson
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION at Home		Length of stay in 1b 3 years	c. CITY OR TOWN Kansas City Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3328 Wabash Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First Ernie	Middle Allen	Last	Month July	Day 25	Year 1960
5. SEX Female	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5/5/91	9. AGE (last birthday) 69	IF UNDER 1 YEAR IF UNDER 24 HR Months 3 Days 20 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (City and state or country) Miami, Missouri	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Alfred allen adams		13b. MOTHER'S MAIDEN NAME Armanda Grant		14. NAME OF HUSBAND OR WIFE Essie Allen	
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. none	17. INFORMANT Address Mrs. Bernice Cooper, Kansas City, Mo.		

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) Uremia		
DUE TO (b) Chronic Glomerular Nephritis		
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Hypertensive Cardio Vascular Disease		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 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 **April 18, 1958** to **July 25, 1960** and last saw her/him alive on **July 25, 1960**
Death occurred at **5:30 P.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Bruce P. Mc Donald MD	22b. ADDRESS 2604 Prospect Avenue	22c. DATE SIGNED 7/26/60
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE July 30, 60	23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery
23d. LOCATION (City, town, or county) (State) Marshall, Missouri		24. FUNERAL DIRECTOR ADDRESS Deepest Gen Marshall, Mo
25. DATE RECD. BY LOCAL REG. 7-26-60		26. REGISTRAR'S SIGNATURE Alva Marshall

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF
Bruce P. Mc Donald
MEDICAL CERTIFICATION

Apr 3 - 0874

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

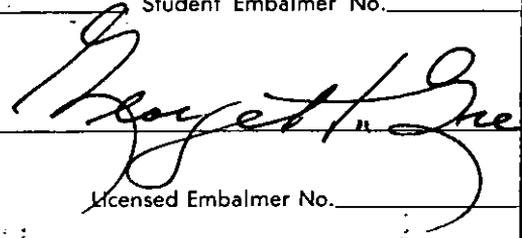
or by _____ Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____



Licensed Embalmer No. _____

P. O. Address _____

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.