

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-041837

FILED VS NOV 23 1960 149

Registration District No. 1002 Primary Registration District No. 1002 Registrar's No. 5463

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		c. CITY OR TOWN <b>Kansas City</b>	
Length of stay in 1b <b>60 years</b>		Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <b>Neurological Hospital</b> INSTITUTION <b>2625 West Paseo</b>		d. STREET ADDRESS (If outside, give location) <b>410 East 70th Terrace</b>	
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 Middle Last <b>Mrs. ORPHA MAY ALLEN</b>			4. DATE OF DEATH Month Day Year <b>October 28th, 1960</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> <b>Married</b>	8. DATE OF BIRTH <b>2/23/88</b>	9. AGE (last birthday) <b>72 years</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	11. BIRTHPLACE (City and state or country) <b>Andalushia, Illinois U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>Nathaniel N. Robinson</b>		13b. MOTHER'S MAIDEN NAME <b>Emma Whaley</b>		14. NAME OF HUSBAND OR WIFE <b>Charles A. Allen</b>	

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>497-36-9438E</b>	17. INFORMANT <b>Charles A. Allen</b> Address <b>410 East 70th Terrace K. C. Mo.</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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b>		<b>5 days</b>
DUE TO (b) <b>Cerebral Disturbance Senile Psychosis</b>		<b>?</b>
DUE TO (c) <b>CBS associated with circulatory disturbance ?</b>		<b>?</b>
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"/> N: <input type="checkbox"/> Unknown

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 **Jan. 30, 1960** to **Oct. 28, 1960** and last saw her **her** live on **Oct. 27th, 1960**  
Death occurred at **7:50 A** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Paul Hines</b> (Degree or title) <b>M.D.</b>	22b. ADDRESS <b>2625 W. Paseo</b>	22c. DATE SIGNED <b>10-28-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>10/31/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Forest Hill Cemetery</b>
23d. LOCATION (City, town, or county) <b>Kansas City, Missouri</b>		(State)
24. FUNERAL DIRECTOR ADDRESS <b>D.W. NEWCOMER'S SONS</b> <b>1331 Brush Creek Blvd. K.C. MO.</b>	25. DATE RECD. BY LOCAL REG. <b>10-31-60</b>	26. REGISTRAR'S SIGNATURE <b>H-L. Dwyer</b>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Paul Hines

21002

1001

1011

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Chester K Brown

Licensed Embalmer No. 4931

P. O. Address KC 448

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.

02-22-61

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