

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-016816

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 72 Primary Registration District No. 3013 Registrar's No. 79

AMENDED

FILED MAY 26 1961

1. PLACE OF DEATH a. COUNTY <u>CLAY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>CLAY</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>NORTH KANSAS CITY</u>		c. CITY OR TOWN <u>KANSAS CITY NORTH</u>	
Length of stay in lb <u>1 DAY</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>NORTH KANSAS CITY MEM. HOSP.</u>		d. STREET ADDRESS (If outside, give location) <u>6803 No. OAK</u>	
Yes <input 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 <u>ERNEST LANGERN ALLARD</u>			4. DATE OF DEATH Month Day Year <u>5-15-1961</u>			
5. SEX <u>MALE</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>4-28-1901</u>	9. AGE (last birthday) <u>60</u>	IF UNDER 1 YEAR	IF UNDER 24 HR
				Months	Days	Hours

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INSURANCE SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONTINENTAL CASUALTY CO.</u>		11. BIRTHPLACE (City and state or country) <u>SIMPSON, ILL.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>JOHN ALLARD</u>		13b. MOTHER'S MAIDEN NAME <u>IDA UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>RAGNILD ALLARD</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.		17. INFORMANT <u>MRS RAGNILD ALLARD</u>		Address <u>6803 N. OAK K.C. MO. No.</u>	
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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) <u>Acute Circulatory Failure</u>			<u>2 hours</u>	
DUE TO (b) <u>Massive myocardial Infarction</u>			<u>3 days</u>	
DUE TO (c) <u>Arteriosclerotic and thrombotic Coronary Occlusion</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Essential Hypertension Exogenous Obesity</u>			PART II. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

19. WAS AUTOPSY PERFORMED? YES <input checked="" 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.)	
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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
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21. I attended the deceased from <u>5-13-61</u> to <u>5-15-61</u> and last saw him alive on <u>5-15-61</u>		
Death occurred at <u>9 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) <u>[Signature]</u>	22b. ADDRESS <u>4030 Noak KC 16 Mo.</u>	22c. DATE SIGNED <u>5-18-61</u>

23. BURIAL, CREMATION, REINTERMENT (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county)	(State)
<u>BURIAL</u>	<u>5-18-61</u>	<u>WHITE CHAPEL CEM.</u>	<u>GLADSTONE,</u>	<u>Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>B.W. NEW COMERS SONS N.K.C. Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>5-18-61</u> 26. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

Mr. CORMICK

MAY 31 1961

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 Glenn H. Hill

Licensed Embalmer No. 4586

P. O. Address K.C. 18, 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.