

# SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

6480-51-044458  
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6480

AMENDED

FILED JAN 15 1962

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Jackson</u>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY <u>Jackson</u> |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br><u>Kansas City</u>                         | Length of stay in 1b.<br><u>20 years</u> | c. CITY OR TOWN<br><u>Kansas City</u>   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION<br><u>1112 E 42nd St</u> |  | d. STREET ADDRESS (If outside, give location)<br><u>1112 E 42nd St</u>  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

|  |                                  |   |   |  |   |
|--|----------------------------------|---|---|--|---|
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><u>Margaret Ambrosia Alloway</u>                             |                                  |   | 4. DATE OF DEATH<br>Month Day Year<br><u>Dec 25 1961</u>            |  |   |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>9-11-73</u>                                  | 9. AGE (last birthday)<br><u>88</u>          | IF UNDER 1 YEAR<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>housewife</u>          |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>home</u>  | 11. BIRTHPLACE (City and state or country)<br><u>Kirkville, Mo.</u> | 12. CITIZEN OF WHAT COUNTRY<br><u>U.S.A.</u> |   |
| 13a. FATHER'S NAME<br><u>Unknown</u>   |                                  | 13b. MOTHER'S MAIDEN NAME<br><u>Isabelle Clark</u>  | 14. NAME OF HUSBAND OR WIFE<br><u>Ralph</u>                         |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u> |                                  | 16. SOCIAL SECURITY NO.<br><u>None</u>  | 17. INFORMANT<br><u>Marjean James, 4119 Forest K.C. Mo</u>          |  |   |

|   |                            |  |
|---|----------------------------|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).<br>PART I. DEATH WAS CAUSED BY:                           |                            | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 years</u>   |
| IMMEDIATE CAUSE (a)   | <u>Chronic Myocarditis</u> |  |
| DUPLICATE TO (b)  | <u>Arteriosclerosis</u>    |  |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |

|  |   |  |
|--|---|--|
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour a.m. p.m.<br>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<br>COUNTY STATE |
|--|--|--|

21. I attended the deceased from April 26, 1960 to Dec 25, 1961 and last saw her alive on Dec 23, 1961  
Death occurred at Dec 25, 1961 11:00 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

|   |   |   |
|---|---|---|
| 22a. SIGNATURE (Ink or title)<br><u>Frank E. Day D.O.</u>   | 22b. ADDRESS<br><u>4314 89th, AtkMo 12266</u> | 22c. DATE SIGNED<br><u>12-26-61</u>                         |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u> | 23b. DATE<br><u>12-26-61</u>                  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Maryville, Mo.</u> |

|   |   |   |
|---|---|---|
| 24. FUNERAL DIRECTOR<br><u>Price Mortuary, Maryville Mo</u> | 25. DATE RECD. BY LOCAL REG.<br><u>12-27-61</u> | 26. REGISTRAR'S SIGNATURE<br><u>Ruth Long</u> |
|---|---|---|

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Frank E. Day

ITEM NO. SHOULD READ

**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 John R. Sidman  
Licensed Embalmer No. 4531  
P. O. Address Kansas City

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.