

No. 2
11-10-39
5-17-39
f. x. 22

AUG 14 1940
399

Registration District No. _____ Primary Registration District No. **1002**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **Jackson**

(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
1211 Prospect
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community **45 years**
years, months or days

3. (a) PRINT FULL NAME **Mrs. Alice O. Allan** **450**

3. (b) If veteran, name war **none**

3. (c) Social Security No. **none**

4. Sex **Female** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **T. Frank Allan**

6. (c) Age of husband or wife if alive **69** years

7. Birth date of deceased **April 9, 1875**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	65	2	28	hr. _____ min. _____

9. Birthplace **Maine**
(City, town, or county) (State or foreign country)

10. Usual occupation **At home**

11. Industry or business _____

12. Name **Don't Know**

13. Birthplace **Don't Know**
(City, town, or county) (State or foreign country)

14. Maiden name **Don't Know**

15. Birthplace **Don't Know**
(City, town, or county) (State or foreign country)

16. (a) Informant **T. Frank Allan**

(b) Address **1211 Prospect**

17. (a) **Burial** (b) Date thereof **July 9, 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Washington**

18. (a) Signature of funeral director **Freeman Mortuary**

(b) Address **104 W. 42nd St., K.C., Mo.**

19. (a) **July 8, 1940** (b) **M. M. Brown**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**

(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")

(d) Street No. **1211 Prospect**
(If rural, give location)

(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **7**
year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from **1931** to **July 7, 1940**, 19____;
that I last saw her alive on **July 6, 1940**, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma left Ovary 9 yrs**

Due to **Carcinomatous**

Due to **Metastases to Sigmoid, liver, lungs**

Other conditions **etc**

Major findings: **Obstruction Sigmoid**
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place) Means of injury _____

23. Signature **John H. Ogilvie** (M. D. or other) _____
Address **730 Prof Bldg** Date signed **7/8/40**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 _____

_____, Registered Apprentice No. _____

working under my personal supervision.

Signed *Clarence H. Chiles*

Licensed Embalmer No. *3473*

P. O. Address *76 E 760*

130-5730
Clarence H. Chiles

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 this body is not embalmed, above space should be left blank.