

Registration District No.

Primary Registration District No.

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: K.C. General Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. 5 days  
(Specify whether  
In this community. same  
years, months or days)

3. (a) PRINT FULL NAME Allen infant

3. (b) If veteran, name war. --- 3. (c) Social Security No. ---

4. Sex. Male 5. Color or race. W. 6. (a) Single, widowed, married, divorced. Single  
6. (b) Name of husband or wife. --- 6. (c) Age of husband or wife if alive. --- years

7. Birth date of deceased. Oct. 17th 1940  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
5 hr. --- min.

9. Birthplace. K.C. Mo. 0  
(City, town, or county) (State or foreign country)

10. Usual occupation. None

11. Industry or business. ---

MOTHER FATHER  
12. Name. George B. Allen  
13. Birthplace. Kentucky  
(City, town, or county) (State or foreign country)  
14. Maiden name. Florence Jones  
15. Birthplace. Utah  
(City, town, or county) (State or foreign country)

18. (a) Informant. Record clerk

(b) Address. K.C. Gen. Hospital, K.C. Mo.

17. (a) Burial (b) Date thereof. 10-23-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. Green lawn

18. (a) Signature of funeral director. H.H. Howell

(b) Address. 644 Labadie

19. (a) 10-23-40 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State. Missouri (b) County. Jackson  
Kansas City  
(c) City or town. Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 6230 E. 14th  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? --- years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month. Oct. day. 22nd  
year. 1940 hour. 7 minute. 30 P. M.

21. I hereby certify that I attended the deceased from 10-17-40, 19---, to 10-22-40, 19---;  
that I last saw him alive on 10-22-40, 19---;  
and that death occurred on the date and hour stated above.

Immediate cause of death. Premature  
Due to. 154  
Due to. ---

Other conditions. Pulmonary congestion and edema  
(Include pregnancy within 3 months of death)  
congestion of all organs

Major findings:  
Of operations. ---  
Of autopsy. See above

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) (e) Means of injury. ---  
23. Signature. Drury P. Howell (M. D. or other)  
Address. Med. Dir. K.C. Gen. Hospital, K.C. Mo.

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

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

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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

*Paul A. Whiting*

Licensed Embalmer No.

*3122*

P. O. Address

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