

13-40
7-39
X23159

Registration District No. 399

Primary Registration District No. 1002

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

1. PLACE OF DEATH: Jackson,
 (a) County Kansas City,
 (b) City or town (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Mercy Hospital,
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 day (Specify whether
 In this community 1 day
 years, months or days)

3. (a) PRINT FULL NAME Shirley Allen.
 3. (b) If veteran, name war no. 3. (c) Social Security No. no.

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced Child
 6. (b) Name of husband or wife X 6. (c) Age of husband or wife if alive X years
 7. Birth date of deceased July 10 1937
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>8</u>	<u>3</u>	<u>17</u>	hr. <u> </u> min. <u> </u>

9. Birthplace Missouri, (City, town, or county) (State or foreign country) 0

10. Usual occupation X 0

11. Industry or business X 0

MOTHER FATHER {
 12. Name Cecil Allen,
 13. Birthplace Missouri, (City, town, or county) (State or foreign country)
 14. Maiden name Melen Doris Hosteter,
 15. Birthplace Cole Gate, Missouri. (City, town, or county) (State or foreign country)

16. (a) Informant Cecil Allen,
 (b) Address Harrisonville, Mo.

17. (a) Removal (b) Date thereof 10-28-40
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Harrisonville, Mo.
Stine & McClure,

18. (a) Signature of funeral director 3235 Gillham Plaza, K. C., Mo.
 (b) Address

19. (a) 10-28-40 (b) M. H. Crowe
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri, (b) County
 (c) City or town Harrisonville, (If outside city or town limits, write "RURAL")
 (d) Street No. 500 Elm Street, (If rural, give location)
 (e) If foreign born, how long in U. S. A.? no years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 27th
 year 1940 hour 9:20 minute P. M.

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

Immediate cause of death Anginal heart disease
Influenza pneumonia

Due to 19
 Due to 19

Other conditions
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations
 Of autopsy

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

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 (M. D. or other)
 Address Date signed

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 *E. M. Plank*

Licensed Embalmer No. *1848*

P. O. Address *K. C. 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, fact should be so stated above.