

No. 2
-13-40
17-39
X23159

FEB 18 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 1251
Registrar's No. 211

Registration District No. 399 Primary Registration District No. 1002

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 1 day
(Specify whether
In this community
years, months or days)

3. (a) PRINT FULL NAME Barbara Allen

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Child

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept. 8 1940
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
4 6 hr. min.

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

10. Usual occupation Child

11. Industry or business _____

MOTHER FATHER { 12. Name Warren Allen
13. Birthplace Missouri
(City, town, or county) (State or foreign country)

{ 14. Maiden name Frances Baker
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Warren Allen
(b) Address 1420 Madison St.

17. (a) Burial (b) Date thereof 1 15 41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Greenlawn

18. (a) Signature of funeral director Weilert Funeral Home
(b) Address 2332 Monitor Plaza; K. C. Mo.

19. (a) Jan 15, 1941 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City
(If outside city or town limits, write "RURAL") 3
(d) Street No. 1003 Cherry
(If rural, give location) 0
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 14th
year 1941 hour 1 minute 35 A. M.

21. I hereby certify that I attended the deceased from 1-13-41, 19____, to 1-14-41, 19____;
that I last saw her alive on 1-14-41, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Bilateral bronchopneumonia
Due to _____ 197
Due to _____
Other conditions W.D.R.F.
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy See above
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? _____

(Specify type of place) _____
While at work? _____ (Specify means of injury) 0
23. Signature Quayle R. Thow (M. D. or other) _____
Address Med. Dir. K.C. Gen. Hospital Date signed _____

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

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..... *Blaine E. Weelant*
Licensed Embalmer No..... *4075*
P. O. Address..... *2332 Monitor Pk*

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.