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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **10941**

Registration District No. **404** Primary Registration District No. **5558** Registrar's 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:
109 East 79th Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **59 Years**
years, months or days

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. **109 East 79th Street**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME **Mrs. Hilda Margaret Allison**
3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **March** day **20th**
year **1941** hour **3** minute **25 A.** M.

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Mr. Mathew B. Allison** 6. (c) Age of husband or wife if alive **66** years
7. Birth date of deceased **November 14 1876**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Dec 22** 19**40** to **March 20** 19**41**
that I last saw her alive on **Jan 21** 19**41**
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	64	4	6	hr. _____ min.

Immediate cause of death **Myocardial infarction**
Chrom. Int. Nephritis
Due to **Acute congestive cardiac failure and pulmonary emphysema**
Duration **24 hours**
Other conditions _____

9. Birthplace **Unknown** **New Jersey**
(City, town, or county) (State or foreign country)

Other conditions (include pregnancy within 3 months of death) _____

10. Usual occupation **Housewife**
11. Industry or business _____
12. Name **Knute T. Batman**
13. Birthplace **Sweden**
(City, town, or county) (State or foreign country)
14. Maiden name **Hannah Lidman**
15. Birthplace **Sweden**
(City, town, or county) (State or foreign country)

PHYSICIAN
Major findings: Of operations **none**
Of autopsy **none**
Underline the cause to which death should be charged statistically.

16. (a) Informant **Maurice R. Allison**
(b) Address **109 E. 79th St.**
17. (a) **Burial** (b) Date thereof **March 22, 1941**
(Burial, cremation, or removal) (Month) (Day) (Year)

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? _____

18. (a) Signature of funeral director **O. H. Newcomer's Sons**
(b) Address **1401 Brush Creek Blvd**
19. (a) **3-25-41** (b) **A. V. Lindsey & Sons**
(Date received local registrar) (Registrar's signature)

23. Signature **J. J. Brannon M.D.** (M. D. or other) **D**
Address **408 1/2 W 75** Date signed **2/20/41**

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

8000

MOTHER FATHER

11-5
Jale M. Finkbeiner

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: *C. Hervey Quisenberry*

Licensed Embalmer No. *40700*

P. O. Address *R. 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.