

1-4-41
5-17-39
X26390

FILED SEP 12 1941
Registration District No. 299

Primary Registration District No. 1002

Registrar's No. 3131

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: Trinity Lutheran Hospital Room 124
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 Days (Specify whether
In this community 30 Years (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 042
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL") 5
(d) Street No. 3601 East 34th Street
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____ 0

3. (a) PRINT FULL NAME Mrs. Carrie Marie Allen

3. (b) If veteran, name war No 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 Mr. Phil Allen 6. (c) Age of husband or wife if alive 41 years

7. Birth date of deceased. apr 21 1905
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
36 3 27 hr. min.

9. Birthplace Statesville North Carolina
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Robert L. Troutman

13. Birthplace Unknown N. Carolina
(City, town, or county) (State or foreign country)

14. Maiden name Orna Moreland

15. Birthplace Unknown N. Carolina
(City, town, or county) (State or foreign country)

16. (a) Informant Phil A. Allen

(b) Address 3601 East 34th Street

17. (a) Burial (b) Date thereof Aug. 21 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill Cemetery

18. (a) Signature of funeral director D. H. Newcomer's Sons

(b) Address 1401 Brush Creek Blvd.

19. (a) 8/19/41 (b) M. M. Crow
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 18th
year 1941 hour 10 minute A. M.

21. I hereby certify that I attended the deceased from 8-14-41
to _____ 19_____
that I last saw her alive on 8-18-41 19_____
and that death occurred on the date and hour stated above.

Immediate cause of death Arterio -
Post-op. Duration _____

Due to _____ 4:00

Due to _____ H/A

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

Major findings: Pre-malignant
Of operations Cervix & uterus
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) (e) Means of injury _____

23. Signature Robert H. Myers (M. D. or other) M.D.

Address 1025 Quail Bldg Date signed 8-18-41

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

10.25.19
1-5

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.....

4070

P. O. Address.....

A C M

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.