

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED APR 8 1943

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

8963

State File No. _____

Registration District No. 199

Primary Registration District No. 1002

Registrar's No. 1500

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: General Hospital No. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3-17-43-3-26-43
In this community 22 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. 1232 Agnes
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME LENA ALLEN

3. (b) If veteran, name war none
3. (c) Social Security No. none

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

6. (b) Name of husband or wife James S. Allen
6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased July 4 1894
(Month) (Day) (Year)

8. AGE: Years 48 Months 8 Days 22
If less than one day _____ hr. _____ min.

9. Birthplace Canton Mississippi
(City, town, or county) (State or foreign country)

10. Usual occupation unemployed

11. Industry or business _____

12. Name Jesse Brown

13. Birthplace Canton Mississippi
(City, town, or county) (State or foreign country)

14. Maiden name Letha Jones

15. Birthplace Canton Miss
(City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk
(b) Address General Hospital #2

17. (a) Burial (b) Date thereof 3-30-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland KC

18. (a) Signature of informant [Signature]

(b) Address 1819 E. 15th St. KC Mo

19. (a) 3-29-43 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 26
year 1943 hour 2:10 minute p. M.

21. I hereby certify that I attended the deceased from March 17 1943 to March 26 1943
that I last saw her alive on March 26 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Post-operative shock following colostomy

Due to Stricture of rectum (probably granuloma inguinal)

Due to 44a

Other conditions (Include pregnancy within 3 months of death)

Major findings: rectal stricture

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) _____
(b) Means of injury _____

23. Signature [Signature] (M. D. or other) _____
Address Gen. Hosp. #2-600622 Date signed 3-29-43

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

MOTHER FATHER

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.....

W. G. Johnson

Licensed Embalmer No. 2211

P. O. Address. 1819 E. 15th K02

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.