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5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

38365 ✓

State File No. ....

NOV 18 1943

Registration District No. 150

Primary Registration District No. 5572

Registrar's No. 137

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Rural - Prairie View  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution Jackson County Home  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 21 days (Specify whether)

In this community  (Yes or No)  
years, months or days

3. (a) PRINT FULL NAME MARGARET Allen

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

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

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

7. Birth date of deceased Dec. 25, 1862  
(Month) (Day) (Year)

8. AGE: Years 80 Months 10 Days 7 If less than one day hr. min.

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

10. Usual occupation Retired

11. Industry or business Housewife

12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant Records - J. C. Home

(b) Address Little Blue, Mo.

17. (a) Burial (b) Date thereof 11-6-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lee's Summit, Mo.

18. (a) Signature of funeral director N B Langford

(b) Address Lee's Summit, Mo.

19. (a) Nov. 5, 1943 (b) F. M. Delich  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson  
(c) City or town Kansas City, Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No. 802 Deland  
T.C. Mo. (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country USA

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 2  
year 1943 hour 11:30 minute 9 M.

21. I hereby certify that I attended the deceased from 10/11  
1943 to 10/11 1/2 1943  
that I last saw him alive on 11/1 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Senility

Due to .....

Due to .....

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

Major findings: Of operations 162h

Of autopsy .....

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 J. W. Sweeney (M. D. or other)

Address Independence Date signed 11/3/43

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

MOTHER FATHER

1162

(Licensed Embalmer's Statement on Reverse Side)

**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..... 

Licensed Embalmer No. 3823

P. O. Address Lee's Summit

**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.**