

STANDARD CERTIFICATE OF DEATH

State File No. **18137**
Registrar's No. **4979**

Registration District No. **318**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County St. Louis, Mo.
(b) City or town Chanute
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Barnes Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 14 days
(Specify whether in this community years, months or days)

3. (a) PRINT FULL NAME JAMES ARTHUR ALLEN

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

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

6. (b) Name of husband or wife Marion D. Allen 6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased September 13 1884
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
61 8 18 hr. min.

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

10. Usual occupation Lawyer

11. Industry or business

12. Name Robert Newton Allen

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

14. Maiden name Ada Wickard

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

16. (a) Informant Mrs. Marion D. Allen

(b) Address Chanute, Kansas

17. (a) Removal (b) Date thereof 6-1-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chanute, Kansas

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) JUN 3 1946 J. F. Bredeek
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Neosho
(c) City or town Chanute
(If outside city or town limits, write "RURAL")
(d) Street No. 214 E. 9th St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 31
year 1946 hour 7 minute 05 P.M.

21. I hereby certify that I attended the deceased from May 17 1946 to May 31 1946;
that I last saw him alive on May 31 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Heart failure Duration 10 days

Due to Anemia 5 mos

Due to Chronic lymphatic leukemia 86/10 mos

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations 74

Of autopsy Chronic lymphatic leukemia

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 Boyd E. Hayward (M. D. or other)
Barnes Hospital Address Date signed

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

MOTHER FATHER

6268

NOV 27 1948

AUG 23 1957

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 *Elmo R. Padwell*

Licensed Embalmer No. 4077

P. O. Address.....

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.