

**FILED JUL 31 1946**  
 Registration District No. 1779

Primary Registration District No. 1002

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

**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: St. Lukes Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 4 Days  
 In this community 42 Years  
years, months or days (Specify whether)

**3. (a) PRINT FULL NAME** Clarence E. Allen  
 3. (b) If veteran, name war No  
 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 Carrie M. Allen  
 6. (c) Age of husband or wife if alive 66 years  
 7. Birth date of deceased November 1, 1876  
(Month) (Day) (Year)

**8. AGE:** Years 69 Months 8 Days 13  
If less than one day hr. min.

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

10. Usual occupation Transfer Business

11. Industry or business

12. Name L. G. Allen

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

14. Maiden name Belle Mc Carty  
(City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs. Carrie M. Allen

(b) Address Kansas City, Missouri

17. (a) Removal (b) Date thereof 7-14-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Stafford, Kansas

18. (a) Signature of funeral director Freeman Mortuary

(b) Address Kansas City, Missouri

19. (a) 7-14-46 (b) Heraldine Helmes  
(Date received local registrar) (Registrar's signature)

**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. 3747 Wyoming  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month July day 14  
 year 1946 hour 2:40 minute A.M.

21. I hereby certify that I attended the deceased from July 11  
 1946, to July 14 1946  
 that I last saw him alive on 7-12-46, 1946;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage  
 Due to Hypertension + Atherosclerosis

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions 83a!  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy none performed

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?  
(Specify type of place)

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Eulis W. Wheelbarrow (M. D. or other)  
 Address Phy. Med. Bldg. Date signed 7-14-46

Duration

4 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

**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 Elmer E. Wasserman

Licensed Embalmer No. 481

P. O. Address Kansas City, 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.**