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17-39

FEDERAL SECURITY AGENCY

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **24058**
Registrar's No. **3054**

Office of Vital Statistics
FILED AUG 7 1947

Registration District No. **1002**

Primary Registration District No. **1002**

Registrar's No. **3054**

1. PLACE OF DEATH:

(a) County: **Jackson**

(b) City or town: **Jacksn City Mo**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **585 Forrest**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: **52 years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: **Mo** (b) County: **Jackson**

(c) City or town: **Kansas City**
(If outside city or town limits, write "RURAL")

(d) Street No.: **585 Forrest**
(If rural, give location)

(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country: _____

3. (a) PRINT FULL NAME: **Eugena Allington**

3. (b) If veteran, name war: **No**

3. (c) Social Security No.: **None**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **7** day **18** year **1947** hour _____ minute **52** M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____ and that death occurred on the date and hour stated above.

4. Sex: **Female**

5. Color or race: **Wgo**

6. (a) Single, widowed, married, divorced: **2**

6. (b) Name of husband or wife: **Wm Allington**

6. (c) Age of husband or wife if alive: _____ years

7. Birth date of deceased: **Sept 20 1885**
(Month) (Day) (Year)

Immediate cause of death: **Cardiac Failure**

Due to: **Hypertensive Heart Disease**

Due to: **Chronic Nephritis**

Other conditions: **Serivity**
(Include pregnancy within 3 months of death)

8. AGE: Years **57** Months **9** Days **28** If less than one day _____ hr. _____ min.

Major findings: **131b**

Of operations: _____

Of autopsy: **No-Permit**

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

10. Usual occupation: **None**

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 _____

MOTHER FATHER

11. Industry or business: _____

12. Name: **J Austin**

13. Birthplace: **Missouri**
(City, town, or county) (State or foreign country)

14. Maiden name: **Unknown**

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

Physician: _____

Underline the cause of which death should be charged statistically.

16. (a) Informant: **Leon Evans**

(b) Address: **585 Forrest**

17. (a) **Burial** (b) Date thereof: **7-28-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: **Funeral Home**

23. Signature: **Hullman** (M. D. or other) **D. E.**

Address: **2686 - Brooklyn** Date signed: _____

18. (a) Signature of funeral director: **H B Moor**

(b) Address: **1820 East 15 st**

19. (a) **7-21-47** (b) **Reraldine Holmes**
(Date received local registrar) (Registrar's signature)

7-21-47

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

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

HB Moore

Licensed Embalmer No.

2410

P. O. Address

1820 E 18 st

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.