

No. 2
-12-45
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **27563**
Registrar's No. **3652**

FILED SEP 8 1947
Registration District No. **749**

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: **GENERAL HOSPITAL NO. 2**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **10 DAYS**
In this community **4 YRS.**
(Specify whether 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. **1305 TROOST**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **ALONZO ALLEN**

3. (b) If veteran, name war **World War I**
3. (c) Social Security No. **unknown**

4. Sex **MALE** 5. Color or race **NEGRO**
6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **LEOLA ALLEN**
6. (c) Age of husband or wife if alive **46** years

7. Birth date of deceased **MAY 23, 1897**
(Month) (Day) (Year)

8. AGE: Years **50** Months **3** Days **0**
If less than one day hr. min.

9. Birthplace **POINT PLEASANT MISSOURI**
(City, town, or county) (State or foreign country)

10. Usual occupation **LABORER**

11. Industry or business

12. Name **GEORGE ALLEN**

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

14. Maiden name **MARY DOCKSEY**

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

16. (a) Informant **LEOLA ALLEN (WIFE)**
(b) Address **1305 TROOST**

17. (a) **Burial** (b) Date thereof **8/29/47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Lincoln Cemetery**

18. (a) Signature of funeral director **Walden Boyd**

(b) Address **1729 Lydia Way**

19. (a) **8-26-47** (b) **Geraldine Holman**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **AUGUST** day **23**,
year **1947** hour **5:** minute **00** P. M.

21. I hereby certify that I attended the deceased from **AUGUST 13**, 19 **47** to **AUGUST 23**, 19 **47**;
that I last saw him alive on **8-23**, 19 **47**
and that death occurred on the date and hour stated above.

Immediate cause of death **RHEUMATIC AND TRICUSPID VALVULITIS** Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy **SAME AS ABOVE**

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) (Means of injury)

23. Signature **[Signature]** (M. D. or other) **M. D.**

Address **GENERAL HOSPITAL NO. 2** Date signed **8/25/47**

MAR 14 1955

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.....

Lester L. Lilly

....., Registered Apprentice No. *73*

working under my personal supervision.

Signed.....

D. B. Reid

Licensed Embalmer No. *2889*

P. O. Address. *2586 Benton*

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.