

FILED FEB 7 1948 *49*

Registration District No. _____

Primary Registration District No. *1002*

Registrar's No. *368*

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. 1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 mos. 16 days
(Specify whether years, months or days)
 In this community 50 years
(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. 925 E. 9 St.
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Isabelle Allen
 3. (b) If veteran, name war no
 3. (c) Social Security No. none

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Jan. day 25
 year 1948 hour 7 minute 25 A.M.

4. Sex female 5. Color or race white
 6. (a) Single, widowed, married, divorced wid.
 6. (b) Name of husband or wife Edward
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Jan 26 1867
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov. 9 1947 to Jan. 25 1948
 that I last saw h. er alive on Jan. 25 1948
 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
80 11 29 hr. _____ min.

Immediate cause of death Bronchopneumonia confluent
 Due to _____
 Due to _____

9. Birthplace Russellville Mo
(City, town, or county) (State or foreign country)
 10. Usual occupation Housewife

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

11. Industry or business Solf
 12. Name John Russell
 13. Birthplace Belfast Ireland
(City, town, or county) (State or foreign country)
 14. Maiden name Sarah McGee
 15. Birthplace Ireland
(City, town, or county) (State or foreign country)

Major findings: 186a
 Of operations 18
 Of autopsy See above

16. (a) Informant E. D. Doane
 (b) Address 3229 E 11th
 17. (a) Burial (b) Date thereof 1-29-1948
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Mt. Moriah

PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

18. (a) Signature of funeral director C. H. Blackman & Son, Inc
 (b) Address 2825 Independence Blvd.
 19. (a) 1-27-48 (b) Waldine Holmes
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) Accident
 (b) Date of occurrence 11-9-47
 (c) Where did injury occur? Kansas City, Jackson, Mo
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
Above address
 While at work? No (Specify type of place)
 (e) Means of injury Fall
 23. Signature W. W. Hart (M. D. or other) MD
 Address Med. Dir. Gen'l Hosp. Date signed 1-26-48

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

RR McFarland

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 *O. K. McFarland*
Licensed Embalmer No. *4397*
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.

105