

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33402**
4449

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY		b. COUNTY JACKSON	
c. LENGTH OF STAY (In this place) 9 yrs.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY	
d. FULL NAME OF HOSPITAL OR INSTITUTION GENERAL HOSPITAL #2		d. STREET ADDRESS (If rural, give location) 1706 East 19th Street	

3. NAME OF DECEASED (Type or Print) MINDA	a. (First)	b. (Middle)	c. (Last) ALLEN	4. DATE OF DEATH (Month) (Day) (Year) OCTOBER 19 1950
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5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH SEPTEMBER 28 1870	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months	IF UNDER 12 HRS. Hours	IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) TASVILLE, TENNESSEE	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME HENRY RICE	13b. MOTHER'S MAIDEN NAME REBECCA	14. NAME OF HUSBAND OR WIFE Oscar Allen
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. No	17. INFORMANT'S SIGNATURE OR NAME HAZEL RICHARDSON	ADDRESS 1706 East 19th Street
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CARCINOMA OF STOMACH (CLINICAL)		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. PULMONARY CONGESTION & EDEMA		15 1/2

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 9-16, 1950, to 10-19, 1950 that I last saw the deceased alive on 10-19, 1950, and that death occurred at 4:45 P m., from the causes and on the date stated above.

23a. SIGNATURE <i>E. Frank Ellis, MD</i>	(Degree or title) MD	23b. ADDRESS 600 East 22nd Street	23c. DATE SIGNED 10-21-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10/23/50	24c. NAME OF CEMETERY OR CREMATORY Lincoln Cemetery	24d. LOCATION (City, town, or county) (State) Kansas City, Missouri
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DATE REC'D BY LOCAL REG. 10-23-50	REGISTRAR'S SIGNATURE <i>Sheraldine Holmes</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>Watkins Bros.</i>	ADDRESS 1729 Lydia
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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 _____

working under my personal supervision.

Student Embalmer No.

Signed J. Jerome Manlove

Signed.....
Student Embalmer

Licensed Embalmer No. 3994

P. O. Address 2503 Highland

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.