

FILED DEC 6 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 37595

BIRTH NO. 125 REG. DIST. NO. 174 PRIMARY REG. DIST. NO. 3035 Registrar's No. 102

542

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

1. PLACE OF DEATH a. COUNTY Lafayette		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Lafayette	
b. CITY (If outside corporate limits, write RURAL and give township) Lexington		c. CITY (If outside corporate limits, write RURAL and give township) Lexington	
c. LENGTH OF STAY (In this place) Life		d. STREET ADDRESS (If rural, give location) 1323 South St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 13231 South St.			

3. NAME OF DECEASED (Type or Print) JOHN ALLEN FALLMAN			4. DATE OF DEATH (Month) (Day) (Year) Nov. 20, 1950		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Sept. 26, 1950		9. AGE (In years last birthday) 0 Months 1 Days 24 Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Kansas City, Mo.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					

13a. FATHER'S NAME James Mitchell Fallman		13b. MOTHER'S MAIDEN NAME Ilna E. Allen		14. NAME OF HUSBAND OR WIFE xxx none	
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. none		17. INFORMANT'S SIGNATURE OR NAME J. Mitchell Fallman	
				ADDRESS Lexington, Mo	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac failure			INTERVAL BETWEEN ONSET AND DEATH 5710
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Toxic Colitis & Dehydration			
		DUE TO (c) Premature Birth 8 months			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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)	

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		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 Nov 5, 1950, to Nov 20, 1950, that I last saw the deceased alive on Nov 20, 1950, and that death occurred at 1:15 P.M., from the causes and on the date stated above.

23a. SIGNATURE J. Mitchell Fallman		23b. ADDRESS Lexington Mo		23c. DATE SIGNED 11/21/50	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 11/21/50		24c. NAME OF CEMETERY OR CREMATORY Memorial Park	
				24d. LOCATION (City, town, or county) (State) Lexington, Mo.	

DATE REC'D BY LOCAL REG. Nov. 27, 1950		REGISTRAR'S SIGNATURE M. W. ...		25. FUNERAL DIRECTOR'S SIGNATURE Forest T. Tempel, Lexington, Mo	
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Jayne

RECEIVED

12/5/50

DISTRICT HEALTH OFFICE No. 3

District File Number _____

Date Filed 12-5-50

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed *Geo. M. Kean*

Licensed Embalmer No. 2983

P. O. Address *Leungton M.*

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.