

10.300
10.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5688

State File No. 778

FILED FEB 27 1953

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1001 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. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
c. LENGTH OF STAY (in this place) 10 yrs		d. STREET ADDRESS (If rural, give location) 6703 Linden Road	
d. FULL NAME OF HOSPITAL OR INSTITUTION V. A. Hospital			

2108
3000

3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) P. c. (Last) Allen			4. DATE OF DEATH (Month) (Day) (Year) February 5, 1953			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 2-15-1908	9. AGE (In years last birthday) 44	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY Printing		11. BIRTHPLACE (City and State or Foreign Country) Lexington, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Alden Allen	13b. MOTHER'S MAIDEN NAME Alice Finn	14. NAME OF HUSBAND OR WIFE Jean 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) yes WW II	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME V. A. Hospital Records	ADDRESS
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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) Generalized metastatic melanoma		INTERVAL BETWEEN ONSET AND DEATH 2 yrs
		ANTECEDENT CAUSES DUE TO (b) Primary melanoma of the eyelid		3 yrs
		DUE TO (c) As above		
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. As above		191X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION None	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)
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?

22. I hereby certify that I attended the deceased from **10-2**, 1952, to **2-5**, 1953, that the cause of death was **Generalized metastatic melanoma** and that death occurred at **1:10 p m.**, from the causes and on the date stated above.

23a. SIGNATURE Richard C. Schaffer M.D. (Degree or title)	23b. ADDRESS V. A. Hospital, Kansas City, Mo.	23c. DATE SIGNED 2/5/53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 2/6/53	24c. NAME OF CEMETERY OR CREMATORY Memorial Park	24d. LOCATION (City, town, or county) (State) Lexington Mo
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DATE REC'D BY LOCAL REG. 2-6-53	REGISTRAR'S SIGNATURE Heraldine Smith	25. FUNERAL DIRECTOR'S SIGNATURE Stover-McBlure	ADDRESS K.C. Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student

Student Embalmer

Signed

F. S. Walton

Licensed Embalmer No.

2744

P. O. Address

712 17th

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.

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