

FILED FEB 18 1953

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **5692**  
Registrar's No. **281**

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>281</u>	
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u>		c. LENGTH OF STAY (in this place) <u>15 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		d. STREET ADDRESS (If rural, give location) <u>1329 E 28th</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St Lukes Hosp</u>				d. STREET ADDRESS (If rural, give location) <u>1329 E 28th</u>			
3. NAME OF DECEASED a. (First) <u>Sidney</u>			b. (Middle) <u>C</u>		c. (Last) <u>Allison</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 18, 1953</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>10/24/1886</u>	9. AGE (in years last birthday) <u>64</u>	IF UNDER 1 YEAR: MONTHS _____ DAYS _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>sales mgt. for Calif.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>lecturing lec.</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13a. FATHER'S NAME <u>John Allison</u>			13b. MOTHER'S MAIDEN NAME <u>Kahill</u>		14. NAME OF HUSBAND OR WIFE <u>Becil Allison</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>676-03-3949</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Cecil Allison</u> ADDRESS <u>1329 E 28th</u>			
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) <u>Congestive heart failure</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>arterial calcific and mitral valvular disease</u> DUE TO (c) <u>arteriosclerosis</u>					INTERVAL BETWEEN ONSET AND DEATH  <u>421</u>
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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? _____			
22. I hereby certify that I attended the deceased from <u>Pathologist</u> , to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE <u>William D. Joseph</u> (Degree or Title)				23b. ADDRESS <u>195749 Kemmer</u>		23c. DATE SIGNED <u>1-18-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>1/20/53</u>		24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) <u>Kansas</u>	
DATE REC'D BY LOCAL REG. <u>1-19-53</u>		REGISTRAR'S SIGNATURE <u>Geraldine Smith</u>		25. FEDERAL DIRECTOR'S SIGNATURE <u>Stone-McBlure</u>		ADDRESS <u>K.C., Mo.</u>	

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

*George A. Hamnell*

Licensed Embalmer No. *4425*

P. O. Address *300 E. Armstrong*

*N. G. 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.