

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40777

State File No.

FILED JAN 3 1958

5712

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>5712</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 OR TOWN <u>Kansas City</u>)		c. LENGTH OF STAY (in this place) <u>88 yrs</u>		c. CITY OR TOWN <u>Kansas City</u>		d. Is Residence within limits of city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>3202 Washington</u>				STREET ADDRESS (If rural, give location) <u>3202 Washington</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>MARY</u>		b. (Middle) <u>A.</u>		c. (Last) <u>ALLEN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>12 13 54</u>	
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>Wh</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>5-12-1865</u>	
9. AGE (In years last birthday) <u>89</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Clones, Ireland 4</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>John McCarney</u>			13b. MOTHER'S MAIDEN NAME <u>Catherine McDonald</u>			14. NAME OF HUSBAND OR WIFE <u>James Allen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Ann Allen, 3202 Washington, K.C. Mo</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* <u>Cerebral Thrombosis</u>		ANTECEDENT CAUSES					<u>2 mon</u>
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) <u>Arterio Sclerosis</u>					<u>10 yrs</u>
		DUE TO (c) _____					
II. OTHER SIGNIFICANT CONDITIONS		<u>Senility -</u>					<u>332X</u>
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) _____ m.		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>Oct 10</u> , 19 <u>54</u> , to <u>Dec 13</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>Dec 13</u> , 19 <u>54</u> , and that death occurred at <u>6:30</u> p.m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Fredrick C. Lamar, MD</u> (Degree or title)				23b. ADDRESS <u>624 Irving Bldg</u>		23c. DATE SIGNED <u>DEC 14 1954</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>12-16-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>12-14-54</u>		REGISTRAR'S SIGNATURE <u>New Marshall</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Wagner Funeral Home 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.....
Signature of Student Embalmer

Signed *Alvin R. Haunschel*

Licensed Embalmer No. *415*

P. O. Address *K. C. W.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.