

FILED OCT 19 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **33055**  
**4158**BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Kansas City</b>		c. LENGTH OF STAY (In this place) <b>33 years</b>	c. CITY OR TOWN <b>Kansas City</b> d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Joseph Hospital</b>		STREET ADDRESS (If rural, give location) <b>7710 Jarboe St.</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Dr. Leo</b> b. (Middle) <b>M.</b> c. (Last) <b>Allen</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Sept. 23, 1955</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Dec. 24, 1903</b>	9. AGE (In years last birthday) <b>51</b>	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) <b>Dentist</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <b>Lamoni Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>

13a. FATHER'S NAME <b>William C. Allen</b>		13b. MOTHER'S MAIDEN NAME <b>Minnie M. Gorsuch</b>		14. NAME OF HUSBAND OR WIFE <b>Zelpha F. Allen</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Zelpha F. Allen, Kansas City, Mo.</b>	

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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Multiple Pulmonary Embolus</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Chronic Rheumatoid Arthritis</b> DUE TO (c) <b>Fracture dislocation of hip</b> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Multiple Fractures</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6-824</b>	
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) <b>Accident</b>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Highway</b>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>Goodland Kansas</b>	
21d. TIME OF INJURY <b>8-4-55</b>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>Car turned over</b>	

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, 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 <b>Hugh H. Owens</b> (Degree or title) <b>Hugh H. Owens, Coroner</b>		23b. ADDRESS <b>1036 Quatto Bldg</b>		23c. DATE SIGNED <b>9-26-55</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>Sept. 27 1955</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>	
24d. LOCATION (City, town, or county) (State) <b>Kansas City Missouri</b>					

DATE REC'D BY LOCAL REG. <b>9-26-55</b>		REGISTRAR'S SIGNATURE <b>Neve Minshall</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Wagner Funeral Home K.C.-Mo</b>	
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(Licensed Embalmer's Statement or (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.....  
Signature of Student Embalmer

Signed *Alvin R. Haunsche*.....

Licensed Embalmer No. *41*.....

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

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.