

FILED MAR 27 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9016

STATE FILE NUMBER

Registration District No. 146 Primary Registration District No. 4237 Registrar's No. 116

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Lafayette</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Raytown</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Odessa</u> 0540 01 Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>6616 Raytown Rd</u>		Length of stay in lb <u>3 Mo</u>	
		d. STREET ADDRESS	(If outside, give location) Residence on Farm: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Allison</u> Last <u>Allison</u>			4. DATE OF DEATH Month <u>March</u> Day <u>14</u> Year <u>1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 31, 1872</u>	9. AGE (In years last birthday) <u>86</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retire</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bridge Const</u>		11. BIRTHPLACE (City and state or country) <u>German town Pa</u>	
13. FATHER'S NAME <u>Samuel Allison</u>			14. MOTHER'S MAIDEN NAME <u>Sarah Mumper</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>LeLands Allison</u> Address <u>6616 Raytown Rd</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic pneumonia.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 days.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUPLICATE TO (b) <u>Arterial Sclerotic Heart Disease & acute infarct 2 weeks.</u>		
	DUPLICATE TO (c) <u>Generalized Arterial Sclerosis.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4 200</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE

21. I attended the deceased from 3/6/57 to 3/13/57 and last saw her alive on 3/13/57
Death occurred at 1:30 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>H. J. Biggs, M.D.</u>	(Degree or title)	22b. ADDRESS <u>Raytown, Mo</u>	22c. DATE SIGNED <u>3/15/57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>18 March 57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Flora Hillz</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City, Jackson Mo</u>
24. FUNERAL DIRECTOR <u>Flora Hill Mem Chapel</u>		ADDRESS <u>KCMo</u>	25. DATE RECD. BY LOCAL REG. <u>3-18-57</u>
			26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

(Licensed Embalmer's Statement on Reverse Side)

300
1-56

All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

securing the medical certification in the specific manner required by statute.

MAR 15 1957

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 *Everett L. Seel*

Licensed Embalmer No. *486*

P. O. Address *Lawson, Co.*

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.