

FILED MAY 2 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-014053

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1899

300
-57

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, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	918 c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph's Hosp</u>		Length of stay in 1b <u>23 yrs</u>	d. STREET ADDRESS (If outside, give location) <u>7244 Baltimore</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>FRED</u> Middle <u>H.</u> Last <u>ALLEN</u>			4. DATE OF DEATH Month <u>April</u> Day <u>11</u> Year <u>1958</u>		
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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>Mar 14, 1892</u>	9. AGE (In years last birthday) <u>66</u>	10. F UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	11. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Line Operator</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Amer. Tele & Teleg. Co. Cal Jet, Mo.</u>	11. BIRTHPLACE (City and state or country) <u>0</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
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13a. FATHER'S NAME <u>Ulysses Grant Allen</u>	13b. MOTHER'S MAIDEN NAME <u>Alta M. Hayes</u>	14. NAME OF HUSBAND OR WIFE <u>Mabel L. Allen</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>487-01-1783</u>	17. INFORMANT Address <u>Mabel L. Allen, 7244 Baltimore</u>
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18. CAUSE OF DEATH (Enter only one cause per line in (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Postoperative Thoracotomy Pneumonia</u> DUE TO (c) <u>1634</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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.)
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20c. TIME OF INJURY Hour <u>-</u> Month, Day, Year <u>-</u> a.m. <u>-</u> p.m. <u>-</u>	20d. INJURY OCCURRED WHILE AT <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 <u>3/28/58 4/11/58</u>	COUNTY <u>0</u>	STATE <u>4/10/58</u>
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21. I attended the deceased from Death occurred at <u>3:30 AM</u> on <u>3/28/58</u> and last saw <u>him</u> alive on <u>4/10/58</u> on the date stated above; and to the best of my knowledge from the causes stated.

22a. SIGNATURE (Degree or title) <u>W. W. Buckingham M.D.</u>	22b. ADDRESS <u>314 Hwy Bldg</u>	22c. DATE SIGNED <u>4/21/58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4-14-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Hickman Mills, Mo.</u>
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24. FUNERAL DIRECTOR <u>Melody-McGilley-Eylar Funeral Home</u> <u>Woodland-Linwood</u>	25. DATE RECD. BY LOCAL REG. <u>4.13.58</u>	26. REGISTRAR'S SIGNATURE <u>neva marshall</u>
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W. W. Buckingham

MEDICAL CERTIFICATION USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be related. All diseases in Part I must be causally related.



MAY 2 1958

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 *John C. ...*

Licensed Embalmer No. 5027

P. O. Address *...*

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.