

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-036051

FILED VS OCT 16 1959

Registration District No. 49 Primary Registration District No. 1002 Registrar's No. 4754 STATE FILE NUMBER

UNRECORDED

1. PLACE OF DEATH a. COUNTY <u>Jackson</u> b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> Length of stay in 1b <u>3 days</u> c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Trinity Lutheran Hosp.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Kansas</u> b. COUNTY <u>Wyandotte</u> c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>4175 Cambridge</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Russell</u> Middle <u>H.</u> Last <u>Allen</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>1</u> Year <u>1959</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>8-16-96</u>	9. AGE (last birthday) <u>63</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MECHANICAL DEPT K. C. PUBLIC SERVICE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARSHALL</u>		11. BIRTHPLACE (City and state or country) <u>Mo. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>JESSE ALLEN</u>		13b. MOTHER'S MAIDEN NAME <u>VIRGINIA LIBBY</u>		14. NAME OF HUSBAND OR WIFE <u>Ina Allen</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WW1</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT Address <u>INA ALLEN 4175 CAMBRIDGE</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>Cerebro-vascular hemorrhage -</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>arterio sclerosis -</u> DUE TO (c) <u>Hypertension</u>					INTERVAL BETWEEN ONSET AND DEATH <u>50 years</u> <u>? yrs</u> <u>? yrs</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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		20g. COUNTY		20h. STATE			
21. I attended the deceased from <u>July 1954</u> to <u>Sept 1959</u> and last saw her/him alive on <u>Sept 30 - 1959</u> Death occurred at <u>3:00 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>R. Paul Wright M.D.</u>			22b. ADDRESS <u>Kansas City, Mo. 1324 Prof. Bldg.</u>		22c. DATE SIGNED <u>Oct. 1959</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>OCT 3, 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FOREST HILL CEM</u>			
23d. LOCATION (City, town, or county) <u>KANSAS CITY MO.</u>		24. FUNERAL DIRECTOR ADDRESS <u>D.W. Newcomers Sons Kansas City, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>10-2-59</u>			
26. REGISTRAR'S SIGNATURE <u>Melva Minchall</u>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

R. Paul Wright

833-1
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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 Vern Lawler

Licensed Embalmer No. 4915

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