URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS AUG 8 1960

=60=026695

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3842

ENDED

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City
Length of stay in 1b: 3yeare
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION at Home
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City
Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) 3328 Wabash
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First Ernie Middle Allen Last
4. DATE OF DEATH: Month July Day 25 Year 1960
5. SEX: Female
6. COLOR OR RACE: Negro
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 5/5/91
9. AGE (last birthday): 69
IF UNDER 1 YEAR: Months 3 Days 30 IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: home
11. BIRTHPLACE (City and state or country): Miami, Missouri
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Alfred allen adams
13b. MOTHER'S MAIDEN NAME: Armanda Grant
14. NAME OF HUSBAND OR WIFE: Isaac allen
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT Address: Mrs. Bernice Cooper, Kansas City, Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Chronic Glomerular Nephritis
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Hypertensive Cardio Vascular Disease

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 April 18, 1958 to July 25, 1960 and last saw her him alive on July 25, 1960
Death occurred at 5:30 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

MEDICAL CERTIFICATION

22a. SIGNATURE (Degree or title): Bruce P. Mc Donald M.D.
22b. ADDRESS: 2604 Prospect Avenue
22c. DATE SIGNED: 7/26/60

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: July 30, 60
23c. NAME OF CEMETERY OR CREMATORY: Fairview Cemetery
23d. LOCATION (City, town, or county) (State): Marshall, Missouri

24. FUNERAL DIRECTOR: Leuft Funeral Home
ADDRESS: Marshall Mo
25. DATE RECD. BY LOCAL REG.: 7-26-60
26. REGISTRAR'S SIGNATURE: Neva Marshall

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

Nov 3, 0874

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

or by _____ Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

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