

# VIRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-029670

FILED VS. AUG 29 1960

042

Primary Registration District No. 1000

Registrar's No. 892

STATE FILE NUMBER

RECEIVED

<b>1. PLACE OF DEATH</b> a. COUNTY <i>Buchanan</i> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Joseph</i> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Mo. Methodist Hospital</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Buchanan</i> c. CITY OR TOWN <i>St. Joseph</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <i>376 N. Noyes Blvd.</i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <i>Thomas</i> Middle <i>B.</i> Last <i>Allen, Sr.</i>			<b>4. DATE OF DEATH</b> Month <i>August</i> Day <i>21</i> Year <i>1960</i>				
<b>5. SEX</b> <i>Male</i>	<b>6. COLOR OR RACE</b> <i>White</i>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <i>4/11/1893</i>	<b>9. AGE (last birthday)</b> <i>67</i>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HR</b> Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Supt. Swift &amp; Co.</i>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>Swift &amp; Co.</i>		<b>11. BIRTHPLACE</b> (City and state or country) <i>Harrison County</i>		<b>12. CITIZEN OF WHAT COUNTRY</b> <i>U.S.A.</i>	
<b>13a. FATHER'S NAME</b> <i>James A. Allen</i>			<b>13b. MOTHER'S MAIDEN NAME</b> <i>Florence Haley</i>		<b>14. NAME OF HUSBAND OR WIFE</b> <i>Pearl S. Allen</i>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>			<b>16. SOCIAL SECURITY NO.</b> <i>487-09-0183</i>		<b>17. INFORMANT</b> Address <i>Mrs. Thomas B. Allen 376 N. Noyes Blvd.</i>		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Parkinson's Disease</i> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <i>yes</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>A.S.H.D. Cancer. Hypertension</i>				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			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>					
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b>		<b>STATE</b>	
<b>21. I attended the deceased from</b> <i>June 60</i> to <i>August 60</i> and last saw him alive on <i>Aug 21 60</i> Death occurred at <i>7:00 p</i> m on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <i>Mr. Grimes MD</i>				<b>22b. ADDRESS</b> <i>St Joseph Mo</i>		<b>22c. DATE SIGNED</b> <i>8/24/60</i> (State)	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <i>Burial</i>		<b>23b. DATE</b> <i>Aug. 23, 1960</i>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <i>Memorial Park Cemetery</i>		<b>23d. LOCATION</b> (City, town, or county) <i>St. Joseph, Mo.</i>		
<b>24. FUNERAL DIRECTOR</b> ADDRESS <i>Clark Funeral Home St. Joseph, Mo.</i>			<b>25. DATE RECD. BY LOCAL REG.</b> <i>Aug 25, 1960</i>		<b>26. REGISTRAR'S SIGNATURE</b> <i>Wm. Clark Goodell</i>		

BY AFFIDAVIT OF informant M.F. Grimes, MEDICAL CERTIFICATION

**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 Paul F. Clark

Licensed Embalmer No. 5024

P. O. Address St Joseph, 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.