

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-028109

3621

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. \_\_\_\_\_

FILED JUL 22 1963

1. PLACE OF DEATH a. COUNTY <b>Jackson</b> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b> Length of stay in 1b <b>1 day</b> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>General Hospital</b> Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b> c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>4816 E. 18th</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>W.</b> Last <b>Allen</b>			4. DATE OF DEATH Month <b>6</b> Day <b>29</b> Year <b>63</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12/13/85</b>	9. AGE (last birthday) <b>77</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (City and state or country) <b>Mendon, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>America</b>	
13a. FATHER'S NAME <b>Et Isaac Allen</b>			13b. MOTHER'S MAIDEN NAME <b>Clarice Deweese</b>		14. NAME OF HUSBAND OR WIFE <b>Effie Allen</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. _____		17. INFORMANT <b>Effie Allen</b> Address <b>IC Cmo. 4816 E 18th</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>generalized arteriosclerosis with arteriosclerotic heart disease</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ 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)		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 <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 6-28-63 to 6-29-63 and last saw her/him alive on 6-29-63  
 Death occurred on \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE *[Signature]* (Degree or title) \_\_\_\_\_ 22b. ADDRESS **J.C. Mo.** 22c. DATE SIGNED **6-29-63**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 23b. DATE **7-2-63** 23c. NAME OF CEMETERY OR CREMATORY **Rose Hill** 23d. LOCATION (City, town, or county) or (State) **Brookfield Mo.**

24. FUNERAL DIRECTOR **Wright Funeral Home** ADDRESS **Brookfield Mo.** 25. DATE RECD. BY LOCAL REG. **6-29-63** 26. REGISTRAR'S SIGNATURE *[Signature]*

(Licensed Embalmer's Statement on Reverse Side)

DO NOT WRITE ON THIS STUB  
 AMENDED  
 DATE AMENDED  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF  
 ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

VS 300 Rev. 4/59  
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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,

0-12

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Forrest D. Coldenow

Licensed Embalmer No. 4714

P. O. Address K.C. 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.