

AUG 14 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Dr. Schwartz

25640
Do not use this space.

579

1. PLACE OF DEATH

(a) County GREENERegistration District No. 318

(b) Township _____

Primary Registration District No. 2001(c) City SPRINGFIELD(d) Street No. Burge Hospital

Registered No. _____

(e) Length of residence in city or town where death occurred _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 457 Carl Henry Allyn(a) Residence, No. Route #2, Fair Grove, Missouri

(Usual place of abode, if no street address, write county or city)

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

infant

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Infant6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 21, 1938

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, _____ hrs. or _____ min.

122

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as saw mill, bank, etc.

Child

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Route #2, Fair Grove, Missouri13. NAME Ralph Allyn14. BIRTHPLACE (CITY OR TOWN) Tennessee15. MAIDEN NAME Gladys Dorbecker16. BIRTHPLACE (CITY OR TOWN) Billings, Missouri17. INFORMANT Ralph Allyn
(ADDRESS) Route #2, Fair Grove, Mo.

18. BURIAL, CREMATION, OR REMOVAL

PLACE Brighton, Mo. DATE July 24, 193919. FUNERAL DIRECTOR (NAME) H. H. Lohmeyer
(ADDRESS) Springfield, Missouri20. FILED July 24, 1939 Chas. A. George, Jr.
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 23, 1939

22. I HEREBY CERTIFY, That I attended deceased from

6-15-39, 19____, to 7-23-39, 19____I last saw him alive on 7-21-39, 19____. Death is saidto have occurred on the date stated above, at 3:45a.

The principal cause of death and related causes of importance were as follows:

Date of onset

Staphylococci Dermatitis 4-15-39

Other contributory causes of importance:

Malnutrition

Name of operation _____ Date of _____

What test confirmed diagnosis? Culture. Was there an autopsy? No.

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) Luigi J. Schwartz, M.D., M. D.(Address) 342 E. 1st Bldg. Springfield

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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 this body is not embalmed, above space should be left blank.

X