

Registration District No. 334Primary Registration District No. 5465Registrar's No. 69

1. PLACE OF DEATH:

(a) County Harrison Bethany
 (b) City or town Bethany
 (c) Name of hospital or institution: Harrison Co. Home
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 weeks + 3
 In this community all his life (Specify whether years, months or days)

3. (a) PRINT FULL NAME Isaac Newton Allen
 3. (b) If veteran, name war X
 3. (c) Social Security No. 4

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Ida M Allen
 6. (c) Age of husband or wife if alive 78 years
 7. Birth date of deceased 1 9 1854
 (Month) (Day) (Year)

8. AGE: Years 85 Months 9 Days 5 If less than one day hr. 4 min.

9. Birthplace Bethany Mo
 (City, town, or county) (State or foreign country)

10. Usual occupation Tinner

11. Industry or business

MOTHER FATHER
 12. Name Steven Allen
 13. Birthplace Tenn.
 14. Maiden name Mary Masters
 15. Birthplace Tenn
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Dorothy Allen
 (b) Address Bethany Mo

17. (a) Burial (b) Date thereof 11-4-39
 (Burial, cremation, or other) (Month) (Day) (Year)
 (c) Place: burial or cremation Pythian Cemetery

18. (a) Signature of funeral director S. Wilson
 (b) Address Bethany Mo

19. (a) 11-7-39 (b) A. T. Whisler
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State 1 (b) County
 (c) City or town
 (If outside city or town limits, write "RURAL")
 (d) Street No.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 2nd
 year 1939 hour 10:30 minute A M.

21. I hereby certify that I attended the deceased from 10-15-39
 , 19 , to Nov 2 , 1939;
 that I last saw him alive on Oct 30 , 1939;
 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia Duration 10-31-39

Due to

Due to 107 W

Other conditions Senility
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
 (b) Date of occurrence
 (c) Where did injury occur? (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature O. W. Jamison (M. D. or other)
 Address Bethany Mo Date signed 11-4-39

STATE OF ILLINOIS
DEPARTMENT OF HEALTH
BUREAU OF HEALTH
CERTIFICATE No. 11,
1239-1673
DEC 9
1959

FEB 1 1945
JUN 25 1956

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.