DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 40941

Registration District No. 719 Primary Registration District No. 6039 Registrar's No. 195

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.

1. PLACE OF DEATH:
(a) County Saline Marshall Twp
(b) City or town (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Saline County Home (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 49 mo In this community About 74 yrs (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Saline
(c) City or town Rural (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.

3. (a) PRINT FULL NAME William Allen 450
3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive years
7. Birth date of deceased Unknown (Month) (Day) (Year)

8. AGE: Years About 74 Months ✓ Days ✓ If less than one day hr. min.

9. Birthplace Saline Co (City, town, or county) Mo. (State or foreign country)
10. Usual occupation ✓
11. Industry or business ✓
FATHER 12. Name Unknown
13. Birthplace Unknown (City, town, or county) ✓ (State or foreign country)
MOTHER 14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) ✓ (State or foreign country)
16. (a) Informant's own signature County Home Records
(b) Address Marshall Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 2-1939 (Month) (Day) (Year)
(c) Place: burial or cremation County Home Cem
18. (a) Signature of funeral director Campbell-Lewis
(b) Address Marshall Mo
19. (a) 12-2-39 (Date received local registrar) (b) Mary Kent Dep. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 30 year 1939 hour 11 minute 15 P M.

21. I hereby certify that I attended the deceased from About July 1, 1939, to Nov 30, 1939; that I last saw h im alive on Nov 28, 1939; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Carcinoma of Stomach	6 months
Due to	
Due to	
Other conditions (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? (Specify type of place)
While at work? (e) Means of injury

23. Signature John A. Haynes (M. D. or other) Address Marshall Mo Date signed

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8
Register File Number
Date Filed 1/20/39

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

Jas N. Lewis, Registered Apprentice No.

working under my personal supervision.

Signed Jas N Lewis

Licensed Embalmer No. 1171

P. O. Address Marshall

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

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