

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

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

44121

Do not use this space.

1. PLACE OF DEATH

(a) County New Madrid Registration District No. 605
(b) Township Coma Primary Registration District No. 4357
(c) City Parma Mo (d) Street No. _____ St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. 10 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. _____ St. ☐ Parma Mo (Rural)
(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 Infant
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 6, 1939
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
4 23
OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Infant
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Parma Mo (City)

FATHER 13. NAME Thos. Allen Allen

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

MOTHER 15. MAIDEN NAME Bernice Amelia Gissom

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

17. INFORMANT (ADDRESS) Thos. A. Allen (Father)
Parma Mo R. I.

18. BURIAL, CREMATION, OR REMOVAL PLACE Malden Mo DATE Dec 30, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. C. Knight
Parma Mo

20. FILED 12/30/39 Dr. C. W. Husted
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-29, 1939

22. I HEREBY CERTIFY, That I attended deceased from 12-26, 1939, to 12-29, 1939

I last saw him alive on 12-29, 1939. Death is said to have occurred on the date stated above, at 12 P. m.

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

Broncho - Pneumonia

Date of onset 5X

Other contributory causes of importance:

Septic meningitis

Name of operation _____ Date of _____

What test confirmed diagnosis? Urinal 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 None

Nature of injury None

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify _____

(Signed) Dr. C. W. Husted, M. D.
534 (Address) Parma, Mo.

STATEMENT OF LICENSED EMBALMER
CERTIFICATE OF FILING
STATE OF CALIFORNIA

RECEIVED

District Health Officer No. 2,

District File Number 140-518

Date Filed 6-10

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.