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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 13 1940

Registration District No. 578

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 2001

State File No. 2397
Registrar's No. 66

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution —
(Specify whether years, months or days)
In this community —

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Greene
(c) City or town Springfield
(If outside city or town limits write "RURAL")
(d) Street No. 2006 N Elizabeth
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Robert Charles Allen
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 Infant
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased June (Month) 25 (Day) 1938 (Year)

8. AGE: Years	Months	Days	If less than one day
1	7	26	hr. ____ min.

9. Birthplace Springfield (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Infant
11. Industry or business Infant
FATHER
12. Name Robert Martin Allen
13. Birthplace ____ (City, town, or county) Ill (State or foreign country)
MOTHER
14. Maiden name Bertha Lonning
15. Birthplace ____ (City, town, or county) Missouri (State or foreign country)
16. (a) Informant Bertha Lonning
(b) Address 2006 N Elizabeth
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 23 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Republic Mo.
18. (a) Signature of funeral director W. Klingner + Co
(b) Address Springfield Missouri 290
19. (a) 1-23-1940 (Date received local registrar) (b) Chas A George M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 21 year 1940 hour 2 minute 05 A.M.
21. I hereby certify that I attended the deceased from 1-16-, 1940 to 1-21-, 1940 that I last saw him alive on 1-20-, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Hemorrhage from mouth and Gums	5 days
Due to This Child was a Hemophiliac Bled continually for 15 days	
Due to Hemophilia	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations NP	
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 J D Musick (M. D. or other)
Address Springfield Mo Date signed 1-22-40

(Licensed Embalmer's Statement on Reverse Side)

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 William Max [illegible]

Licensed Embalmer No. 4076

P. O. Address Springfield

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

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