

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3595
Registrar's No. 6

Registration District No. 775 Primary Registration District No. 6000-A

1. PLACE OF DEATH:
(a) County St. Francois
(b) City or town Bonne Terre Mo.
(c) Name of hospital or institution: Bonne Terre Hospital 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 hrs. (Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Francois
(c) City or town Centerville Mo.
(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 Fred J. Allen Sr.
8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month January day 10
year 1940 hour 11 minute 5 A. M.

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife O'Russie Allen 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Jan. 31 1898
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan. 10, 1940, to Jan. 10, 1940;
that I last saw him alive on Jan. 10, 1940,
and that death occurred on the date and hour stated above.

8. AGE: Years 41 Months 11 Days 9
If less than one day _____ hr. _____ min.

Immediate cause of death Fracture distal tibia of dorsal spine between 7th & 8th dorsal vertebrae with complete severance of spinal cord at that level. Due to 1 1/2 hr. Main accident in St. Joseph Mo. & mines.
Due to _____

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

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: None Of operations None Of autopsy None

10. Usual occupation Lead miner

11. Industry or business Lead mined
12. Name Tom Allen
13. Birthplace Missouri
14. Maiden name Josephine Gray
15. Birthplace Missouri

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature Fred Allen
(b) Address Centerville - Mo.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence 1-10-40

17. (a) Burial (b) Date thereof 1-13-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Where did injury occur: Keokuk St. Francois Mo.
(City or town) (County) (State)

(c) Place: burial or cremation John W. Weyer

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
In industrial place (Lead mine).
While at work? Yes (Specify type of place) (e) Means of injury Falling rock

18. (a) Signature of funeral director L. Bayer
(b) Address DeLoe 7000 1/2

23. Signature Daniel Edmund (M. D. or other) M.D.
Address Bonne Terre, Mo. Date signed 1-12-40

19. (a) 1-13-40 (b) A. W. Hawkins
(Date received local registrar) (Registrar's signature)

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.

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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..... *C. J. Buyer.*

Licensed Embalmer No. *1671*

P. O. Address..... *Deer Lodge MO*

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.