

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

11651

State File No. \_\_\_\_\_

Registration District No. 528

Primary Registration District No. 5722A

Registrar's No. \_\_\_\_\_

61  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Macon Walling, Ind

(b) City or town CALLAO RURAL

(c) Name of hospital or institution: \_\_\_\_\_

(If not in hospital or institution, write street number or location) 70

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_ (Month, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Macon

(c) City or town CALLAO 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 RANDALL C. ALLEN 450

3. (b) If veteran, name war. \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAR day 13

year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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 MARCH 13 1890

(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days 10 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Pterius Monasterium 10 days

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name ROSS ALLEN

18. Birthplace CALLAO MO (City, town, or county) (State or foreign country)

14. Maiden name LESTER GRIM SHAW

15. Birthplace MACON MO (City, town, or county) (State or foreign country)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant ROSS ALLEN

(b) Address CALLAO MO

17. (a) BURIAL (b) Date thereof 3-14-1940

(Burial, cremation, or removal) (Month) (Day) (Year)

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? \_\_\_\_\_

(c) Place: burial or cremation OLD CHARITABLE CEMETERY

18. (a) Signature of funeral director H. F. Edwards

(b) Address Baviera Mo

19. (a) Apr 3-1940 (b) H. F. Edwards 471

(Date received local registrar) (Registrar's signature)

(Specify type of place) \_\_\_\_\_

While at work? \_\_\_\_\_ (e) Means of injury 2

23. Signature A. L. Hurdin (M. D. or other) Mo.

Address Callao, Mo Date signed 3/13/40

RECEIVED

District Health Officer No: 10

District File Number 4-40-909

Date Filed APR 19 1940

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 \_\_\_\_\_

*J. G. Edwards*

\_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed *J. G. Edwards* \_\_\_\_\_

Licensed Embalmer No. 1961

P. O. Address Brewer 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.