FILED MAY 15 1940

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11-10-39
ev. 5-17-39
I X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 16283

Registration District No. 833 Primary Registration District No. 6096 Registrar's No.

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

1. PLACE OF DEATH:

(a) County SHELBY Taylor Tp
(b) City or town (If outside city or town limits write "RURAL" and name of township)
(c) Name of hospital or institution: Joel Jacob Allen 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community 40 years (Specify whether years, months or days) 150

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Shelby.
(c) City or town Leonard 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 Joel Jacob 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 d

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Feb (Month) 2 (Day) 1860 (Year)

8. AGE: Years 80 | Months 1 | Days 1 | If less than one day hr. min.

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

10. Usual occupation FARMER

11. Industry or business

MOTHER FATHER

12. Name Marshal L Allen
13. Birthplace Dont Know (City, town, or county) 0 (State or foreign country)
14. Maiden name Delpha Paul
15. Birthplace (City, town, or county) Mo (State or foreign country)

16. (a) Informant J. M. Allen
(b) Address Leonard Mo.

17. (a) (Burial, cremation, or removal) (b) Date thereof MAR 24 1940 (Month) (Day) (Year)
(c) Place: burial or cremation New Providence

18. (a) Signature of funeral director E. E. Hopper.
(b) Address Clarence Mo.

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 22
year 1940 hour minute M.

21. I hereby certify that I attended the deceased from Jan 13, 1940, to Mar 22, 1940, that I last saw h alive on Jan 13, 1940, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Broncho pneumonia	3 wks
Due to: influenza	1 wk
Due to:	
Other conditions (Include pregnancy within 3 months of death): none	
Major findings: Of operations: non	
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) no
(b) Date of occurrence no
(c) Where did injury occur? no (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? no (Specify type of place)
While at work? no (e) Means of injury

23. Signature D L Hazen (M. D. or other) 2-6
Address Clarence Mo Date signed April 1940

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 5-40-1024
Date Filed MAY 14 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 .....

....., Registered Apprentice No. .....,

working under my personal supervision.

Signed E E Hopkins

Licensed Embalmer No. 878

P. O. Address Clarence, N

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.

S. No. 2B
—2-21-40
I X22659

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

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BUREAU OF THE CENSUS

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STANDARD CERTIFICATE OF DEATH

State File No. 16283

Registration District No. 833 Primary Registration District No. 6096 Registrar's No.

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

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(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 Joel Owen Allen
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 80 Months 1 Days 1 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) June 19 1940 (b) Mrs E N Gerard
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 22
year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
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?
While at work? (Specify type of place) (e) Means of injury

23. Signature D. L. Harlan (M. D. or other)
Address Clarence Mo Date signed

SUPPLEMENTARY