

MAY 15 1940 865
Registration District No. _____

Primary Registration District No. 6143

1. PLACE OF DEATH:

(a) County Texas
(b) City or town Rural Cross Jct
(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 3 yrs years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Texas
(c) City or town 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

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME Edgar F. Allen 450
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

20. DATE OF DEATH: Month April day 20
year 1940 hour 7 minute 45 P.M.

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Mary 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Sept 16 1893
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from April 20 to April 20, 1940, to April 30, 1940, and that death occurred on the date and hour stated above.

that I last saw him alive on 4/20, 1940.
Immediate cause of death Chronic Hepatitis malignans *Duration*
Chronic

8. AGE: Years 89 Months 7 Days 6
If less than one day _____ hr. _____ min.

Due to Age related senility
Due to _____

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

Other conditions (include pregnancy within 3 months of death) 46

10. Usual occupation Carpenter

Major findings: Of operations _____

11. Industry or business

MOTHER FATHER
12. Name Benjamin Allen
13. Birthplace Maine
(City, town, or county) (State or foreign country)
14. Maiden name Sarah Doan
15. Birthplace Maine
(City, town, or county) (State or foreign country)

Of autopsy none
Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature E. C. Davis

22. If death was due to external causes, fill in the following:

(b) Address Cabool R.R. Mo

(a) Accident, suicide, or homicide (specify) _____

17. (a) Burial (b) Date thereof April 22 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(b) Date of occurrence _____

(c) Place: burial or cremation Union Cemetery Piney Jct Ark

(c) Where did injury occur? _____ (City or town) (County) (State)

18. (a) Signature of funeral director Gaylord V. Elliott

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(b) Address Cabool Mo

While at work? _____ (Specify type of place) (e) Means of injury _____

19. (a) April 23-40 (b) Mrs. Lou Mc Millan
(Date received local registrar) (Registrar's signature)

23. Signature J. P. Worswick M. D. or other _____
Address Cabool Mo Date signed 4-23-40

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.

RECEIVED

District Health Officer No. 5

District File Number 540-515

Date Filed 5-10-40

Signed Gaylord V. Elliott

Licensed Embalmer No. 2252

P. O. Address Calrod 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.