

No. 2
11-10-39
5-17-39
21422

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

17948

State File No. _____

Registration District No. 85

Primary Registration District No. 1001

Registrar's No. 598

1. PLACE OF DEATH:

(a) County Buchanan 2

(b) City or town St. Joseph

(c) Name of hospital or institution:
2601 Patee
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____

In this community 21 years 10 Mo. 21 days (Specify whether years, months or days)

8. (a) PRINT FULL NAME EVA MAE ALLEN 450

8. (b) If veteran, name war none

8. (c) Social Security No. none

4. Sex female 5. Color or race white

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Howard Allen

6. (c) Age of husband or wife if alive 25 years

7. Birth date of deceased July 8th, 1918
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>21</u>	<u>10</u>	<u>21</u>	hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business home

12. Name Earl Younger

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

14. Maiden name Julia Chafin

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

16. (a) Informant Howard Allen

(b) Address 215 W. Isadore St. Joseph

17. (a) Burial (b) Date thereof May 31 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Auburn Cemetery

18. (a) Signature of funeral director FLEEMAN & SON INC.

(b) Address ST. JOSEPH, MO.

19. (a) May 31, 1940 (b) A.J. Nestlebusch
(Date received by local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Buchanan

(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")

(d) Street No. 2601 Patee
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 29
year 1940 hour 1 minute 45 p. M.

21. I hereby certify that I attended the deceased from 5-27, 1940 to 5-29, 1940
that I last saw her alive on 5-29, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Chronic Endocarditis 15 yr
Chronic Myocarditis 15 yr
Due to Rheumatism 15 yr

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations None

Of autopsy Yes

Duration

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? _____

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

23. Signature E. M. Shore (M. D. or other) M.D.
Address 317 Lincoln St. St. Joseph, Mo. Date signed 5-31-40

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

MOTHER FATHER

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. H. Swan

Licensed Embalmer No. 4082

P. O. Address St Joseph

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.