

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

Registration District No. 72 Primary Registration District No. 4041 State File No. _____
Registrar's No. 19

1. PLACE OF DEATH
(a) County Boone
(b) City or town Centuria
(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 2
In this community 400 months (Specify whether years, months or days)

3. (a) PRINT FULL NAME RICHARD LEE ALLEN
3. (b) If veteran, name war _____ 3. (c) Social Security No. 492-12-6250

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced divorced
6. (b) Name of husband or wife Margaret Beckwith Allen 6. (c) Age of husband or wife if native 36 years
7. Birth date of deceased May 4 1899
(Month) (Day) (Year)

8. AGE: Years 44 Months 2 Days 27 If less than one day hr. _____ min. _____

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

10. Usual occupation laborer

11. Industry or business _____

12. Name Joe Allen
13. Birthplace Boone Co Mo
(City, town, or county) (State or foreign country)

14. Maiden name Louanna Mettenger
15. Birthplace Arkansas
(City, town, or county) (State or foreign country)

16. (a) Informant Joe Allen
(b) Address Centuria Mo

17. (a) Burial (b) Date thereof 8-2-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Appeluan Chapel Cen

18. (a) Signature of funeral director Wm. H. Borden
(b) Address Centuria Mo

19. (a) 7/2/40 (b) W. H. Borden
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Boone
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 31st
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.

Immediate cause of death _____ Duration _____

Due to 92 Rifle shot wound in
in head, self inflicted

Due to (SUICIDE)

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings: _____
Of, operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Suicide
(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? 36

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

23. Signature W. H. Borden (M. D. or other) _____
Address 218 St Columbia Date signed 7-2-40

167

11-11-11

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 Mr. Medaus

Licensed Embalmer No. 2589

P. O. Address Centralia 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **24554**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **72**

Primary Registration District No. **4041**

Registrar's No.

1. PLACE OF DEATH:

- (a) County **Boone**
(b) City or town **Centralia**
(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)

3. (a) PRINT
FULL NAME

Richard Lee 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 **ow**

6. (b) Name of husband or wife

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

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

8. AGE: Years Months Days If less than one day
41 2 27 hr. min.

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

10. Usual occupation

11. Industry or business

12. Name

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

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

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.

CERTIFICATION

20. DATE OF DEATH Month **July** day **31**
year **1940** hour minute M.

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.

Immediate cause of death

22 rifle shot wound in head self inflicted

Due to **suicide**

Due to **public place high school yard**

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy **mb**

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?

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

23. Signature **M. R. Toalson** (M. D. or other)

Address **Columbia Mo** Date signed

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

