

Registration District No. **796** Primary Registration District No. **3038**

1. PLACE OF DEATH:

(a) County **Saline**  
(b) City or town **Marshall**  
(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 **about 70 yrs** years, months or days **2**

3. (a) PRINT

FULL NAME **BEN ALLEN**

3. (b) If veteran,

name war

3. (c) Social Security

No.

4. Sex **M**

5. Color or  
race **Col**

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

6. (b) Name of husband or wife **Unknown**

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

7. Birth date of deceased **Unknown**

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

**about 72**

**x**

**x**

hr.

min.

9. Birthplace **Saline Co. Mo.**

(City, town, or county)

(State or foreign country)

10. Usual occupation **Farm work**

11. Industry or business **Farm**

12. Name: **Unknown**

13. Birthplace **Unknown**

(City, town, or county)

(State or foreign country)

14. Maiden name **Unknown**

15. Birthplace **Unknown**

(City, town, or county)

(State or foreign country)

16. (a) Informant **Ernie Allen**

(b) Address **Marshall**

17. (a) **Burial**

(Burial, cremation, or removal)

(b) Date thereof **11-17-40**

(Month) (Day) (Year)

(c) Place: burial or cremation **Fairview Cem.**

18. (a) Signature of funeral director **F. D. Ferguson**

(b) Address **Marshall**

19. (a) **11-16-40**

(Date received local registrar)

(b) **Myary Kent**

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.**

(b) County **Saline**

(c) City or town **Marshall**

(If outside city or town limits, write "RURAL")

(d) Street No. **7 English**

(If rural, give location)

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

years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **12**  
year **1940** hour **6** minute **—** A.M.

21. I hereby certify that I attended the deceased from **held**  
**insignificant**, 19 **—**, to **Nov. 12**, 19 **40**  
that I last saw him alive on **—**, 19 **—**;  
and that death occurred on the date and hour stated above.

Immediate cause of death **Probably**  
**apoplexy.**

Due to **—**

Due to **—**

Other conditions **—**

(Include pregnancy within 3 months of death)

Major findings: **None**

Of operations **—**

Of autopsy **None**

Duration

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

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? **Marshall-Saline-Mo.**

(City or town)

(County)

(State)

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

**Home**

While at work? **no**

(Specify type of place)

(e) Means of injury **—**

23. Signature **B. C. Bradshaw**

(M. D. or other)

Address **Arrow Rock Mo.**

Date signed **11-12-40**

**Coroner, Saline Co., Mo.**

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed 12-12-40

### 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.

Signed F. D. Ferguson

Licensed Embalmer No. 2172

P. O. Address Marshall

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.