

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 1822  
Registrar's No. 52

Registration District No. 85

Primary Registration District No. 1001

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

1. PLACE OF DEATH  
 (a) County BUCHANAN  
 (b) City or town ST. JOSEPH  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: STATE HOSPITAL No. 2  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 29 yrs. & mos. 12 ds.  
 (Specify whether  
 In this community all of life  
 years, months or days)

3. (a) PRINT FULL NAME Ethel Allen  
 3. (b) If veteran, name war \_\_\_\_\_  
 3. (c) Social Security No. \_\_\_\_\_

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced wid.  
 6. (b) Name of husband or wife W.C. Allen 6. (c) Age of husband or wife 1887 years  
 7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years 53 Months 7 Days 7 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation chance worker

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
 12. Name no information  
 13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)  
 14. Maiden name information  
 15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant Wes Blagg  
 (b) Address Maryville Mo.

17. (a) Burial (b) Date thereof 1-15-1941  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Sifford mo

18. (a) Signature of funeral director E.P. Breit  
 (b) Address Savannah mo

19. (a) 1-13-41 (b) E.J. Nestlebuch  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State MO. (b) County Buchanan  
 (c) City or town St. Joseph 7  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 9  
 (If rural, give location) 0  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 12  
 year 1941 hour \_\_\_\_\_ minute 0 M.  
 21. I hereby certify that I attended the deceased from Aug. 11, 1941, to Jan. 12, 1941;  
 that I last saw her alive on Jan. 12, 1941  
 and that death occurred on the date and hour stated above.

Immediate cause of death: Pneumo pneumonia  
post operative  
 Due to refractory  
 Due to 12/12  
 Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)  
 Major findings: Chronic colitis  
Cystic duct - malformation  
 Of autopsy \_\_\_\_\_

Duration  
5 ds.  
14/1  
 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 T. J. Dell (M. D. or other) D  
 Address St. Joseph Date signed 1/13/41

**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. C. Breit  
Licensed Embalmer No. 2650  
P. O. Address Savannah 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.**