

7-39
X23159

FILED FEB 14 1941

STANDARD CERTIFICATE OF DEATH

Registration District No. _____

Primary Registration District No. 2001 ✓

1. PLACE OF DEATH:

(a) County GREENE
(b) City or town Springfield
(c) Name of hospital or institution 1570 Cherry
(If outside city or town limits, write "RURAL" and name of township)
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 54 Years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 1570 Cherry
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Arthur Dexter Allen

3. (b) If veteran, name war World War 3. (c) Social Security No. No

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mollie Allen 6. (c) Age of husband or wife if alive 80 years
7. Birth date of deceased January 31 1859
(Month) (Day) (Year)

8. AGE: Years 81 Months 11 Days 14 If less than one day hr. _____ min. _____

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

10. Usual occupation Retired

11. Industry or business Cemetery Supt.

MOTHER FATHER { 12. Name Rufus C. Allen
13. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Frank Allen
(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof Jan 17 41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maple Park Cem.

18. (a) Signature of funeral director H. H. Lohmeyer
(b) Address Springfield, Mo.

19. (a) 1-17-41 (b) W. E. Handley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 15 year 1941 hour 8 minute 10 p.m.

21. I hereby certify that I attended the deceased from 10/9, 1940, to 1/15, 1941
that I last saw him alive on 1/7, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Inanition - starvation - refused food and
Due to medication - tranquilizer action!
Due to 10/9/40
Heart - hypertensive left heart
Other conditions 47 years
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy No
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? CL
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature W. E. Handley (M. D. or other) _____
Address Springfield, Mo. Date signed 1/17/41

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

250

JAN 11 1945

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 *M J Bradley*

Licensed Embalmer No. *3434*

P. O. Address *Springfield*

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.

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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 2605-
Registrar's No.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 318

Primary Registration District No. 2001

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

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Springfield
(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.
In this community (Specify whether years, months or days)

3. (a) PRINT FULL NAME Arthur Dexter 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 M
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive.

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

8. AGE: Years Months Days If less than one day
81 11 14 hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER { 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.?

20. DATE OF DEATH Month Jan day 15 year 1941 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 transmission of food and medical and
transurethral prosection
Due to 10/7/1940 For benign prostatic hypertrophy. 5oz. residual urine 10 grms. tissue removed.
Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 1370
Of autopsy

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 W. H. Wise (M. D. or other Med.)
Address Holland Bl. Springfield Date signed 4/10/41

SUPPLEMENTAL

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

