

No. 2  
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17-39

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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39853

State File No. \_\_\_\_\_

FILED DEC 7 1943

Primary Registration District No. 6225

Registrar's No. 163

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

1. PLACE OF DEATH:

(a) County Vernon

(b) City or town Meranda (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hosp. No 3. 2 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 mo. 6 mo 4 da (Specify whether years, months or days)

In this community Same time

3. (a) PRINT FULL NAME William Allen

3. (b) If veteran, name war unk. 3. (c) Social Security No. none

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced 2 divorced Widowed

6. (b) Name of husband or wife Deceased 6. (c) Age of husband or wife if alive unk. years 3 (Day) 1864 (Year)

7. Birth date of deceased: May (Month) 3 (Day) 1864 (Year)

8. AGE: Years 79 Months 6 Days ? If less than one day hr. min.

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

10. Usual occupation none

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

12. Name James Allen

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

14. Maiden name Elizabeth Cauthorn

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

16. (a) Informant Hospital Records

(b) Address Merada Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-12-43 (Month) (Day) (Year)

(c) Place: burial or cremation Deerwood Cem.

18. (a) Signature of funeral director Ferry Funeral Home

(b) Address Merada Mo

19. (a) 11-17-43 (Date received local registrar) (b) Ray B. Beurek (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Benton 108

(c) City or town Warsaw (If outside city or town limits, write "RURAL") ?

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 11<sup>th</sup> year 1943 hour 8 minute 50 A. M.

21. I hereby certify that I attended the deceased from Feb. 1<sup>st</sup> 1943 to Nov. 11 1943

that I last saw him alive on Nov. 10 1943 and that death occurred on the date and hour stated above.

Immediate cause of death: Double Decile without Psychosis Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations 162a

Of autopsy \_\_\_\_\_

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 R. B. Hester (M. D. or other) mm

Address Merada Mo Date signed 11-11-43

RECEIVED

District Health District No. 71

District File Number 11-43-1303

Date Filed 12-6-43

**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 MEP

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed Mike E. Ferry

Licensed Embalmer No. 1432

P. O. Address Merida 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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Dec  
Registrar's No. 163

Registration District No. 360

Primary Registration District No. 6220

1. PLACE OF DEATH

(a) County Sevier  
(b) City or town Rural Washington Twp  
(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) (Specify whether

3. (a) PRINT FULL NAME William 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 w

6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive

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

8. AGE: Years 79 Months 6 Days Ind. (If less than one day, 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) W. B. Beuch (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) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July year 1943 hour minute M.

21. I hereby certify that I attended the deceased from 19...; that I last saw him alive on 19...; and that death occurred on the date and hour stated above.

Immediate cause of death

Duration

Due to

Due to

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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. D. or other)

Address Date signed

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

SUPPLEMENTARY

S-39358