

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42083**

FILED JAN 6 1944

Registration District No. **3817**

Primary Registration District No. **166**

Registrar's No. **166**

1. PLACE OF DEATH:

(a) County **Boonville**
(b) City or town **Boonville, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **St Joseph Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 days**. (Specify whether years, months or days)
In this community **4 months**.

3. (a) PRINT FULL NAME **Shave Leon Allen**

3. (b) If veteran, ☒ name war **✓** 3. (c) Social Security No. **✓**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife **✓** 6. (c) Age of husband or wife if alive **24** years (Day) (Year)
7. Birth date of deceased **Aug 24 - 1943** (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
4 1 hr. min.

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

10. Usual occupation **✓**

11. Industry or business **✓**

MOTHER FATHER { 12. Name **Levester Allen**
13. Birthplace **Texas County Mo** (City, town, or county) (State or foreign country)
14. Maiden name **Minnie Walters**
15. Birthplace **Missouri** (City, town, or county) (State or foreign country)

16. (a) Informant **Levester Allen**
(b) Address **Boonville Mo**

17. (a) **Burial** (Burial, cremation, or removal) Date thereof **Dec 26-43** (Month) (Day) (Year)
(c) Place: burial or cremation **Boonville Cemetery**

18. (a) Signature of funeral director **Goodman + Boller**
(b) Address **Boonville Mo**

19. (a) **12-27-43** (Date received local registrar) (b) **Dr. Chas. Swap** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Boonville**
(c) City or town **Boonville Mo** (If outside city or town limits, write "RURAL")
(d) Street No. **Water Street** (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **✓**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **25** year **1943** hour **2** minute **10 A.** M.

21. I hereby certify that I attended the deceased from **Dec 22** 19 **43**, to **Dec 25** 19 **43**.
that I last saw him alive on **Dec 24** 19 **43**, and that death occurred on the date and hour stated above.

Immediate cause of death **Lobar Pneumonia** Duration **3 days**
Due to **Pertussis** **3 weeks**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **9**

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?
(Specify type of place) (e) Means of injury **✓**

23. Signature **J. C. Fincher** (M. D. or other) **MD**
Address **Boonville Mo** Date signed **Dec 25 43**

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

1-3-44

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.....

Licensed Embalmer No.....

P. O. Address.....

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.