

Dr. Bresnell  
FILED MAR 20 1944

State File No. ....

Primary Registration District No. 3074

Registrar's No. ....

1. PLACE OF DEATH:

(a) County Scott  
(b) City or town Sikeston  
(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 40 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Scott <sup>100</sup>  
(c) City or town Sikeston <sup>5</sup>  
(If outside city or town limits, write "RURAL") <sup>3</sup>  
(d) Street No. 620 William St.  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country: 0

3. (a) PRINT FULL NAME

James C. Allen

3. (b) If veteran, name war X 3. (c) Social Security No. 490-03-0961

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M  
6. (b) Name of husband or wife Mina Allen 6. (c) Age of husband or wife if alive 69 years  
7. Birth date of deceased 4 14 1875  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
68 10 3 hr. min.

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

10. Usual occupation Elevator work

11. Industry or business Flour Mill

12. Name David Allen

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

14. Maiden name Eliza Harris 9  
(City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs. Mina Allen  
(b) Address Sikeston Mo. 620 William

17. (a) Burial (b) Date thereof 2/19/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sikeston Mo.  
18. (a) Signature of funeral director H.W. Albritton  
(b) Address Sikeston Mo.

19. (a) 3/5/44 (b) Louis Legend  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 17  
year 1944 hour 5 minute 15 P.M.

21. I hereby certify that I attended the deceased from Feb. 8-1944  
to Feb. 17 1944  
that I last saw him alive on Feb. 17 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial infarction  
Due to cardio-vascular  
Disease

Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death) B1a

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration  
\_\_\_\_\_  
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)  
(c) Means of injury 0  
23. Signature Dr. Bresnell (M. D. or other)  
Date signed 3-2-44

1518

RECEIVED

District Health Office No. 2

District File Number 344-512

Date Filed 3-16-48

SEP 9 1946

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.....

Embalmed

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*Hunter Albritton*

Licensed Embalmer No. 4210

P. O. Address Sikeston Mo.

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

If this body is not embalmed, fact should be so stated above.