

DEPARTMENT OF COMMERCE
BUREAU OF THE COMMERCE

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17410
Registrar's No. 464

FILED MAY 24 1944

Registration District No. 4

Primary Registration District No. 1000

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town Saint Joseph
(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 over a month
(Specify whether
In this community Most of his life
years, months or days)

3. (a) PRINT

FULL NAME William Jackson Allen, Sr.

3. (b) If veteran, ☒

name war.

3. (c) Social Security

No. NONE

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widower
6. (b) Name of husband or wife Jennie Allen 6. (c) Age of husband or wife if alive years
7. Birth date of deceased September 18, 1884
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
59 6 22 hr. min.

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

10. Usual occupation Contractor

11. Industry or business

12. Name Unknown Unknown
13. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Unknown Unknown
15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mitchell Allen

(b) Address Pratt, Kansas

17. (a) Burial (b) Date thereof April 11, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Auburn Cemetery

18. (a) Signature of funeral director Thos. E. Pidenfaden
(b) Address 602 South 10th Street

19. (a) 4-10-44 (b) Rose Henry
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
(c) City or town Saint Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. Route #5
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country 1

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 9
year 1944 hour 6 minute 57 a.m.

21. I hereby certify that I attended the deceased from April 1, 1944, to April 9, 1944
that I last saw him alive on April 8, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis
Cholesterol deposits
Due to Cholesterol thrombosis

Due to 838
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
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 J. P. Leary (M. D. or other)
Address St. Joseph, Mo. Date signed 4/10/44

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

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

Mollie E. Sidenfaden Fox

Licensed Embalmer No.

4235

P. O. Address

St. Joseph, 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.