

25308 41

State File No. _____

FILED JUN 19 1944

Registration District No. 218

Primary Registration District No. 4462

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St. Francois
(b) City or town Cluine
(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) 1
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois
(c) City or town Cluine
(If outside city or town limits, write "RURAL") 1
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME CHARLES R. 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 4

6. (b) Name of husband or wife Mary T. Allen 6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased July 17 (Month) (Day) (Year) 1884

8. AGE: Years 59 Months 9 Days 26 If less than one day hr. _____ min. _____

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

10. Usual occupation Miner

11. Industry or business _____

12. Name James Allen

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

14. Maiden name Mary White

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

16. (a) Informant Monis C. Allen

(b) Address Cluine, MO.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 4 1944 (Month) (Day) (Year)

(c) Place: burial or cremation old fellow grave yard, Duport

18. (a) Signature of funeral director Frank Smith

(b) Address _____

19. (a) 5-20-44 (Date received local registrar) (b) Frank Smith (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 12th year 1944 hour 7 minute A. M.

21. I hereby certify that I attended the deceased from Coroner's Investigation to May 12 1944 that I last saw him alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Heart Disease Duration 3 yrs.

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 94

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? No (Specify type of place) (e) Means of injury None

23. Signature Caroline Clavell (M.D. or other) Coroner

Address Boone Tenn MO Date signed 5/12/44

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

4
13

1373

RECEIVED

District Health Officer No. 4
District File Number 644-3989
Date Filed 6-17-44

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 Everett Sparks

Licensed Embalmer No. 4287

P. O. Address Short River 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.