DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 26010

FILED JUL 17 1944

Registration District No. 3974

Primary Registration District No. 6275

Registrar's No.

1. PLACE OF DEATH:

(a) County North
(b) City or town Allendale (Smith) (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 1 (Specify whether
In this community Life years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County North 113
(c) City or town Allendale Mo. (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

3. (a) PRINT FULL NAME Allen Dale Daniels

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 D

6. (b) Name of husband or wife

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

7. Birth date of deceased April (Month) 27 (Day) 1939 (Yr)

8. AGE: Years 7 | Months 7 | Days 7 | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER
12. Name Ora Mae Daniels
13. Birthplace Allendale Mo. (City, town, or county) (State or foreign country)

FATHER
14. Maiden name Ellen Sarah Daniels
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant Ora Mae Daniels
(b) Address Allendale, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-1-44 (Month) (Day) (Year)
(c) Place: burial or cremation Kirk Cemetery

18. (a) Signature of funeral director Jack C. Dunkle
(b) Address Grant City, Mo.

19. (a) June 5-1944 (Date received local registrar) (b) Arlene Scudder (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month May day 31
year 1944 hour 6 minute A M.

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

	Duration
Immediate cause of death Suffocation from burning Home was also destroyed by fire	instant
Due to Kerosene can Containing kerosene exploding.	
Due to Pouring Kerosene into a Range Stove with fire in	
Other conditions Fire box (Include pregnancy within 3 months of death)	

Major findings:
Of operations 8-1-1
Of autopsy 10-1-15

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) accident
(b) Date of occurrence 5-31-44
(c) Where did injury occur? Allendale (City or town) North (County) Co. Mo. (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home
While at work? (Specify type of place) (e) Means of injury

23. Signature Jack C. Dunkle Coroner (M. D. or other)
Address Grant City, Mo. Date signed 6-1-44

1104

(Licensed Embalmer's Statement on Reverse Side)

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..... Jack C. Dunfee

Licensed Embalmer No..... 3252

P. O. Address..... Grant City

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

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Mercy

Registration District No. 37 Primary Registration District No. [redacted]4549 Registrar's No. 9

1. PLACE OF DEATH:

(a) County Worth

(b) City or town Allendale, Mo.
(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 years, months or days)

In this community

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

3. (a) PRINT FULL NAME Allen O. Daniels

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 S

6. (b) Name of husband or wife

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

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

8. AGE: Years 7 | Months 7 | Days | If less than one day: hr. min.

9. Birthplace (City, town, or county) Mo. (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)

MOTHER

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) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May 31 day year 1944 hour 6 minute M.

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

	Duration
Immediate cause of death	
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

26010