

FILED SEP 8 1944

State File No. _____
Registrar's No. 279

Registration District No. 53

Primary Registration District No. 3010

1. PLACE OF DEATH:

(a) County Cape Girardeau Mo
(b) City or town Cape Girardeau Mo
(c) Name of hospital or institution St Francis Hospital
(d) Length of stay: In hospital or institution 9 days
In this community 9 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Stoddard Mo
(c) City or town Bell City Mo
(d) Street No. _____
(e) Citizen of foreign country? No (Yes or No)

3. (a) PRINT FULL NAME DONALD LEONARD 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. Single

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

7. Birth date of deceased July 4, 1944 (Month) (Day) (Year)

8. AGE: Years _____ Months 1 Days 21 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name James Earl Allen
13. Birthplace East Prairie, Mo (City, town, or county) (State or foreign country)
14. Maiden name Mildred Skaggs
15. Birthplace Newbern, Tenn (City, town, or county) (State or foreign country)

16. (a) Informant James Earl Allen (b) Address Bell City, Mo

17. (a) Burial (b) Date thereof 8-23-44 (Month) (Day) (Year)

(c) Place: burial or cremation Mounds - New Madrid

18. (a) Signature of general director Travis Shelby

(b) Address East Prairie, Mo

19. (a) 8-24-44 (b) G. W. Phelps (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 21 year 1944 hour 10 minute 7 P. M.

21. I hereby certify that I attended the deceased from 7-22-1944 to 8-21-1944 that I last saw him alive on 8-20-1944 and that death occurred on the date and hour stated above.

Immediate cause of death: ilioscolitis

Due to _____

Due to _____

Other conditions: _____ (include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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) (e) Means of injury _____

23. Signature K. W. ... (M. D. or other) _____

Address Cape Girardeau Mo Date signed 8/21/44

Duration 30 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

16
1
4

1014

RECEIVED

District Health Officer No. 4
District File Number 944-4295
Date Filed 9-7-44

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 _____
working under my personal supervision.

Registered Apprentice No. _____
Not embalmed
Signed *Yvonne Shelly*

Licensed Embalmer No. 2726
P. O. Address East Prarie, 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.