

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED NOV 22 1944

State File No. _____

Registration District No. 59

Primary Registration District No. 5230

Registrar's No. 171

1. PLACE OF DEATH:

(a) County CASS
(b) City or town RURAL RAYMORE
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1 1/2 MI. SOUTH RAYMORE
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community 28 YEARS
years, months or days)

3. (a) PRINT FULL NAME GEORGE EDWARD ALLEN

3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED
6. (b) Name of husband or wife NEELIE H. ALLEN 6. (c) Age of husband or wife if alive ✓ years
7. Birth date of deceased MAY 18 1859
(Month) (Day) (Year)

8. AGE: Years 85 Months 5 Days 21 If less than one day
hr. _____ min. _____

9. Birthplace HARLEM N.Y.
(City, town, or county) (State or foreign country)

10. Usual occupation RETIRED FARMER

11. Industry or business

12. Name JOHN ALLEN
13. Birthplace N.J.
(City, town, or county) (State or foreign country)
14. Maiden name SUSAN HAMMOND
15. Birthplace UNKNOWN
(City, town, or county) (State or foreign country)

16. (a) Informant MRS. C.F. WATKINS
(b) Address RAYMORE, MO.

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

(c) Place: burial or cremation GREEN VALLEY, ILL.

18. (a) Signature of funeral director G. R. Bryant Sons

(b) Address BELTON MO.

19. (a) Nov. 11, 1944 (b) Margaret Valle
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County CASS 19
(c) City or town RURAL RAYMORE 0
(If outside city or town limits, write "RURAL")
(d) Street No. 1 1/2 MI. SOUTH RAYMORE 3
(If rural, give location)
(e) Citizen of foreign country? ✓ (Yes or No)
If yes, name country ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV. day 9th
year 1944 hour 10 minute 30 AM.

21. I hereby certify that I attended the deceased from 11
9, 1944 to 11 - 9, 1944
that I last saw him alive on 11 - 9, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death

Coronary occlusion

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

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) (e) Means of injury ✓

23. Signature R. M. Miller (M. D. or other)

Address Belton Mo Date signed 11-10-44

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

EMBR 20 1945

APR 11 1945

DEC 11 1931

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.....

Licensed Embalmer No. 3645

P. O. Address.....

Grandman, 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.