

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38911

State File No.

FILED DEC 13 1944
Registration District No. 324

Primary Registration District No. 3072

Registrar's No. 192

1. PLACE OF DEATH: Saline
(a) County: Marshall
(b) City or town: (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Fitzgibbons hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 2 weeks
(Specify whether)
In this community: all her life
(years, months or days)

3. (a) PRINT FULL NAME: Frances Elizabeth Allen
3. (b) If veteran, name war: no
3. (c) Social Security No. none

4. Sex: female
5. Color or race: white
6. (a) Single, widowed, married, divorced: married
6. (b) Name of husband or wife: M. F. Allen
6. (c) Age of husband or wife: 87 years
7. Birth date of deceased: October 2 1855
(Month) (Day) (Year)

8. AGE: Years 89 Months 1 Days 15
If less than one day hr. min.

9. Birthplace: Saline Co. Mo. (City, town, or county) (State and foreign country)

10. Usual occupation: housewife

11. Industry or business:

12. Name: John B. West

13. Birthplace: Va. (City, town, or county) (State and foreign country)

14. Maiden name: Sarah Gregory

15. Birthplace: Va. (City, town, or county) (State and foreign country)

16. (a) Informant: M. F. Allen

(b) Address: Slater, Mo.

17. (a) Burial (Burial, cremation, or other) (b) Date thereof: 11-19-'44
(Month) (Day) (Year)

(c) Place: burial or cremation: Marshall, Mo.

18. (a) Signature of funeral director: Hill Brothers,

(b) Address: Slater, Mo.

19. (a) 11-19-44 (b) Mrs. F. O. West (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo. (b) County: Saline 97
(c) City or town: Slater 2
(If outside city or town limits, write "RURAL")
(d) Street No. 1
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country: D

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: NOV. day: 17th, year: 1944 hour: 5 minute: 45 p.m.

21. I hereby certify that I attended the deceased from Oct 22 1944 to Nov 17 1944
that I last saw him alive on Nov 17 1944
and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary Thrombosis
Duration: 12 hrs.

Due to: Internal injuries Oct 22 44

Due to: Fall in home - Fracture upper femur Oct 22 44

Other conditions: Fracture left hip Oct 22 - 44
(Include pregnancy within 3 months of death)

Major findings: None
Of operations: None

Of autopsy: None

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): Fall in home

(b) Date of occurrence: Oct 22 - 44

(c) Where did injury occur? at home Slater Mo

(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: Fall

23. Signature: J. E. West (M. D. or other)

Address: Slater Mo Date signed 11-19-44

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 12-12-94

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

Sam M. Hill

Licensed Embalmer No.

1292

P. O. Address

State 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.