

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 19 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Registration District No. 10

Primary Registration District No. 3033

1. PLACE OF DEATH:

(a) County LACLEDE
(b) City or town LEBANON
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
325 N. MADISON
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1
(Specify whether years, months or days) ALWAYS

3. (a) PRINT FULL NAME MARION DUFF ALLEN

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

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married, divorced WIDOWER
6. (b) Name of husband or wife ELIZABETH J. McGINNIS 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased MAY 9 - 1963
(Month) (Day) (Year)

8. AGE: Years 81 Months 7 Days 7 If less than one day
hr. _____ min. _____

9. Birthplace FRANKLIN Co ILL
(City, town, or county) (State or foreign country)

10. Usual occupation POLICE JUDGE

11. Industry or business _____

12. Name WM C ALLEN

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

14. Maiden name MARGARET MOORE

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

16. (a) Informant Sam Allen
(b) Address LEBANON MO

17. (a) BURIAL (b) Date thereof 12-20-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation LEBANON

18. (a) Signature of funeral director PALMER'S

(b) Address LEBANON MO

19. (a) 12-29-44 (b) Grace Roper
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County LACLEDE 53
(c) City or town LEBANON
(If outside city or town limits, write "RURAL")
(d) Street No. 325 N. MADISON
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country MO

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC, day 16TH, year 1944 hour 5 minute P M.

21. I hereby certify that I attended the deceased from 16 - 1944 to DEC 16 - 1944
that I last saw him alive on DEC 16 - 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia
Thrombosis & emb. at base.

Due to _____

Due to 94A

Other conditions (Include pregnancy within 3 months of death) None

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 J H CANN (M. D. or other) D

Address Lebanon MO Date signed 12-16-44

1090

(Licensed Embalmer's Statement on Reverse Side)

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

Given

Laclede County Health Unit

File No. 12-44-172

Date Filed 1/48/45

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 *Allyn Dethlefsen Hooker*

Licensed Embalmer No. 4333

P. O. Address Lebanon, 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.