

FILED APR 5 1945

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Hawell  
(b) City or town West Plains Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: West Plains Hospital  
(If not in hospital or institution, write street number & location)  
(d) Length of stay: In hospital or institution 6 hours  
(Specify whether  
In this community no yrs  
years, months or days)

3. (a) PRINT FULL NAME Oliver J. Allen

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife John Allen 6. (c) Age of husband or wife if alive 86 years  
7. Birth date of deceased Sept 4th 1858  
(Month) (Day) (Year)

8. AGE: 86 Years 5 Months 22 Days If less than one day  
hr. min.

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant John Allen  
(b) Address Mountain View Mo.

17. (a) Burial (b) Date thereof 2/28-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mtn View Cem.

18. (a) Signature of funeral director John H. Brown

(b) Address Mtn View Mo.

19. (a) 3/7/45 (b) Cruth Hunt  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Hawell  
(c) City or town Mountain View Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 26th  
year 1945 hour 11 minute 15 P.M.

21. I hereby certify that I attended the deceased from Feb 26 1945 to Feb 26 1945  
that I last saw her alive on Feb 26 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Sarcoma of R. Ovary  
Benignity

Due to \_\_\_\_\_

Other conditions 490  
(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)  
(c) Means of injury 0

23. Signature C.R. Terrell (M. D. or other) \_\_\_\_\_

Address Mtn View Mo. Date signed 3-6-45

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

**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.

Signed.....

Registered Apprentice No.....

Licensed Embalmer No.....

P. O. Address.....

**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.**