

FILED MAY 8 1945
298

Registration District No. _____

Primary Registration District No. 4448

Registrar's No. 8

1. PLACE OF DEATH:

(a) County Ray

(b) City or town Lawson
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location) 1

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ray

(c) City or town Lawson
(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 _____

3. (a) PRINT FULL NAME WILLIAM H ALLEN

(b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M 5. Color or race W

6. (a) Single, widowed, married, divorced married

6. (c) Age of husband or wife if alive 82 years (Day) (Year)

7. Birth date of deceased Oct 15 1869
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

85 6 12 hr. min.

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

10. Usual occupation Farming

11. Industry or business _____

MOTHER FATHER

12. Name Joan Allen

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

14. Maiden name Hester Rogger

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

16. (a) Informant My Merara Allen

(b) Address Lawson Mo

17. (a) Burial (b) Date thereof Apr 29 '45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calmira

18. (a) Signature of funeral director Jarman Prichard

(b) Address Lawson Mo

19. (a) April 25, 1945 H. A. Beach
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 27
year 1945 hour 10 A.M. minute _____ M.

21. I hereby certify that I attended the deceased from Dec 26 1944 to April 27 1945
that I last saw him alive on April 26 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Marasmus
Cardiac Failure

Due to Carcinoma of colon

Due to Chronic Aortitis

Other conditions Fracture of Rt. Humerus
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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)

(c) Means of injury _____

23. Signature John Prichard (M. D. or other)
Address Lawson Date signed April 27 1945

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

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 5/7/45

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 Claude P. Richard

Licensed Embalmer No. 2751

P. O. Address Excelsior Springs, 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.

Registration District No. 298

Primary Registration District No. 4448

1. PLACE OF DEATH:

(a) County Ray
(b) City or town Lansan
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (years, months or days)

3. (a) PRINT FULL NAME

Wm H. 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 M

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

7. Birth date of deceased Oct 11 1911
(Month) (Day) (Year)

8. AGE: Years 85 Months 6 Days 1 (less than one day) _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER { 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 _____
(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec 27
year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____

that I last saw him _____ alive on _____, 19____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

Due to _____
Due to _____

Other conditions climbed fractured R/H hum
(Include pregnancy within 3 months of death)
at shoulder

Major findings: _____
Of operations _____

Of autopsy _____

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 Dec 26, 1944
(c) Where did injury occur? Lansan Ray Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
in home
While at work? _____ (Specify type of place)
(e) Means of injury fall

23. Signature Wm H. Allen (M. D. or other)
Address Lansan Mo Date signed _____

SUPPLEMENTARY

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

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