V. S. No. 2
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ev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 14 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 17629

Registration District No. 239 Primary Registration District No. 5825 Registrar's No. 4356

1. PLACE OF DEATH:

(a) County New Madrid

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

(c) Name of hospital or institution: 2½ mi. Northeast of Malden (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution none (Specify whether In this community all of life years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid

(c) City or town Rural (If outside city or town limits, write "RURAL")

(d) Street No. 2½ mi. Northeast of Malden (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Jimmie Doyle Allen

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Infant

6. (c) Age of husband or wife if alive --- years

7. Birth date of deceased October (Month) 19 (Day) 1944 (Year)

8. AGE: Years 0 | Months 6 | Days 26 | If less than one day ____ hr. ____ min.

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

10. Usual occupation Infant

11. Industry or business none

FATHER
12. Name Virgil Allen
13. Birthplace ____ (City, town, or county) Tennessee (State or foreign country)

MOTHER
14. Maiden name Leona Wheeler
15. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)

16. (a) Informant H. B. Franks
(b) Address Box 387, Malden, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-15-45 (Month) (Day) (Year)
(c) Place: burial or cremation Malden Memorial

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

19. (a) 5/12/45 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 14 th year 1945 hour 11 minute 55 A.M.

21. I hereby certify that I attended the deceased from May 11, 1945 to May 14, 1945 that I last saw him alive on May 13, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death [illegible] Accidentally

Due to Burns Cuts

Due to ←

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations ← 107

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 ←

(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? (Specify type of place)

While at work? ← (e) Means of injury 5

23. Signature [illegible] (M. D. or other)

Address [illegible] Date signed May 15 45

1946 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No.
District File Number 645-819
Date Filed 6-12-45

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

NOT EMBALMED, Registered Apprentice No.

working under my personal supervision.

Signed

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.