

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registrar's No. 11

Registration District No. 37

Primary Registration District No. 4049

1. PLACE OF DEATH:

(a) County Boone
(b) City or town Centralia
(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 40 years years, months or days

3. (a) PRINT FULL NAME

Hannie Allen

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

4. Sex Female 5. Color or race White
6. (b) Name of husband Henry Allen 6. (c) Age of husband or wife if alive 81 years
7. Birth date of deceased Dec 29 1867 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
77 5 24 hr. min.

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

10. Usual occupation House wife

11. Industry or business

12. Name John M. Keenan

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

14. Maiden name A. H. Long

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

16. (a) Informant Henry Allen

(b) Address Centralia, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-24-1945 (Month) (Day) (Year)

(c) Place: burial or cremation Hickory Grove Church

18. (a) Signature of funeral director W. H. Wright

(b) Address Centralia, Mo

19. (a) 6-23-1945 (Date received local report) (b) W. H. Wright (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Boone
(c) City or town Centralia (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 June day 23 year 1945 hour 1 minute 20 A. M.

21. I hereby certify that I attended the deceased from June 18, 1945, to June 23, 1945; that I last saw her alive on 9th of death 6-23, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion Duration 1 hr

Due to Angina Pectoris Major 152 pm

Due to _____

Other conditions (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) (e) Means of injury ✓

23. Signature R. P. Roberts (M. D. or other) Co

Address Centralia, Mo Date signed 6-23-45

RECEIVED
District Health Officer No. 9,
District File Number _____
Date Filed 2-9-45

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 _____

Licensed Embalmer No. 4313

P. O. Address Centerville 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.