DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 7 1945

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 28683

Registration District No. 340 Primary Registration District No. 6151 Registrar's No. 21

1. PLACE OF DEATH:

(a) County Stoddard

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

(c) Name of hospital or institution: Elk Twp
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Stoddard

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

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Mary Alice Allred

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

4. Sex F 1 5. Color or race W 6. (a) Single, widowed, married, divorced S 0

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

7. Birth date of deceased Feb (Month) 8 (Day), 1869 (Year)

8. AGE: Years 76 Months 5 Days 13 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housework

11. Industry or business _____

FATHER
12. Name John H. Allred
13. Birthplace _____ (City, town, or county) Tenn (State or foreign country)

MOTHER
14. Maiden name Margaret Robison
15. Birthplace _____ (City, town, or county) Ark (State or foreign country)

16. (a) Informant's own signature Mrs. Edna Flowers
(b) Address Parma Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-22-45 (Month) (Day) (Year)
(c) Place: burial or cremation Russellville Ark

18. (a) Signature of funeral director Watkins Fun. Service
(b) Address Parma Mo.

19. (a) 8-8-45 (Date received local registrar) (b) Cordie Miller (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 21 year 1945 hour 7 minute 15 A M.

21. I hereby certify that I attended the deceased from Mar 13, 1945, to July 21, 1945; that I last saw her alive on July 19, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cardiac Decomp	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
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 _____

(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 _____

23. Signature Geo W Husted (M. D. or other)

Address Parma Mo Date signed 7/21/45

(Licensed Embalmer's Statement on Reverse Side)

1B3

Rev. 5-17-39 I X19311

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED
District Health Office No. 2
District File Number 945-2998
Date Filed 9-6-45

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 Lyman Steele

Licensed Embalmer No. 2476

P. O. Address Dexter 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, above space should be left blank.