

30651

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED SEP 27 1945

Primary Registration District No. 302J

Registrar's No. 90

Registration District No.

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

1. PLACE OF DEATH:

(a) County Howell

(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: 1
(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 Howell ⁴⁶

(c) City or town West Plains Mo ¹
(If outside city or town limits, write "RURAL.")

(d) Street No. _____ (If rural, give location) ⁰

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

If yes, name country _____

3. (a) PRINT FULL NAME William C. Allen

3. (b) If veteran, name war ✓

3. (c) Social Security No. 80

4. Sex mo 5. Color or race w 6. (a) Single, widowed, married, divorced 80

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

7. Birth date of deceased: unk ? unk unk
(Month) (Day) (Year)

8. AGE: Years 67 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name J J Allen

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

14. Maiden name Mary C. Balfour

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

16. (a) Informant G. Allen

(b) Address West Plains Mo

17. (a) B (b) Date thereof 8 31 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Callaway Cem

18. (a) Signature of funeral director W. J. ...

(b) Address West Plains Mo

19. (a) 7-45 (b) ...
(Date received local Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 29
year 45 hour 6 minute 45 am

21. I hereby certify that I attended the deceased from Aug. 28
19 45 to Aug. 29, 19 45
that I last saw h im live on Aug. 28, 19 45
and that death occurred on the date and hour stated above.

Immediate cause of death Injury from fall. Duration _____
Internal injury to lungs 27hrs.
and bowels.

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: 1860-5
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) Accident

(b) Date of occurrence Aug. 28, 1945, 12:30 A.M.

(c) Where did injury occur? West Plains, Howell, Mo. ⁴⁶

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
He fell in a deep ditch, while crossing a ditch, lay in the ditch all night.

Signature Art Thornburgh (M. D. or other) 9/7/45
Address West Plains, Mo. Date signed

1125

Thornburgh

RECEIVED

District Health Officer No. 5,

District File Number 945-388

Date Filed 9-2-46

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.....

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. OctRegistration District No. 141Primary Registration District No. 3025Registrar's No. 90

1. PLACE OF DEATH:

(a) County Hawell
(b) City or town West Plains
(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 days3. (a) PRINT FULL NAME Wm C 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 S

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

7. Birth date of deceased mh
(Month) (Day) (Year)8. AGE: Years 67 Months _____ Days _____ If less than one day _____ min.

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

10. Usual occupation Retired laborer11. Industry or business Laborer - Retired

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 9-7-45 (b) Gaul Harlin
(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 _____ year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 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 _____
(Include pregnancy within 3 months of death)Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

30651