

FILED NOV 8 1945
Registration District No. **33**

Primary Registration District No. **3010**

1. PLACE OF DEATH:

(a) County Cape Girardeau
(b) City or town Cape Girardeau
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Francis Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 24 days
(Specify whether
In this community 24 days
years, months or days)

3. (a) PRINT FULL NAME EVELYN ALLEN

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

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife — 6. (c) Age of husband or wife if alive — years
7. Birth date of deceased Aug 13, 1945
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
— 1 22 hr. min.

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

10. Usual occupation Baby

11. Industry or business

12. Name Marvin Allen
13. Birthplace Essex, Mo
(City, town, or county) (State or foreign country)
14. Maiden name Margaret Robinson
15. Birthplace Lawrenceburg, Tenn
(City, town, or county) (State or foreign country)

16. (a) Informant Marvin Allen
(b) Address Sikeston, Mo
17. (a) Burial (b) Date thereof 10-6-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park, Sikeston
18. (a) Signature of funeral director Walter Funeral Home
(b) Address Sikeston, Mo

19. (a) 10-27-1945 (b) E. S. Summers
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Scott
(c) City or town Sikeston, Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 709 W. Malone
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 5
year 1945 hour 8 minute 10 A.M.

21. I hereby certify that I attended the deceased from 9/11 1945 to 10/5 1945
that I last saw him alive on 10/5 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Enteritis, chronic, C.R. Duration —

Due to —

Due to —

Other conditions 119W
(Include pregnancy within 3 months of death)

Major findings: Of operations —

Of autopsy none

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 Chas. J. Kerl (M. D. or Other)
Address Cape Girardeau, Mo Date signed 10/1/45

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

MOTHER FATHER

RECEIVED

District Health Officer No. 4

District File Number 1145-1271

Date Filed 11-6-45

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.....

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.