

FILED NOV 30 1945

Registration District No. 337

Primary Registration District No. 44-956138

Registrar's No. 70

1. PLACE OF DEATH:

(a) County Shelby County
(b) City or town Rural Bethel Mo.
(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 days) 19 yrs.

3. (a) PRINT FULL NAME Clarence Irl Allen

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

4. Sex M O 5. Color or race W 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Mildred Allen 6. (c) Age of husband or wife if alive 38 years

7. Birth date of deceased July 2 1890
(Month) (Day) (Year)

8. AGE: Years 55 Months 3 Days 18 If less than one day hr. _____ min. _____

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER

12. Name John R. Allen
13. Birthplace Not known Kentucky
(City, town, or county) (State or foreign country)
14. Maiden name Jessica Savage
15. Birthplace Not known Not known
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Mildred Allen
(b) Address Bethel Mo.

17. (a) Burial (b) Date thereof Oct 27-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Staffensville Cemetery

18. (a) Signature of funeral director W. Mesgrove
(b) Address Bethel, Missouri

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Shelby
(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. 3 1/2 mi. South of Staffensville
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 20
year 1945 hour 7 minute 30 P.M.

21. I hereby certify that I attended the deceased from 4 September 1945 to Oct 20 1945
that I last saw him alive on Oct 20th 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Hemorrhage Duration 12 hrs

Due to Cardio-vascular Rival disease
Due to Heart know

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?

23. Signature Clarence Irl Allen (Specify type of place) _____ (e) Means of injury _____
Address Bethel Mo. (M. D. or other) _____
Date signed _____

WRITE PLAINLY - USE UNFADING BLACK INK

RECEIVED

District Health Officer No. 10

District File Number 11-45-172

Date Filed NOV 27 1945

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 Self Registered Apprentice No. _____ working under my personal supervision.

Signed C. W. Cunningham

Licensed Embalmer No. 2719

P. O. Address Bethel 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.

Registration District No. 337

Primary Registration District No. 6128

Registrar's No. 70

1. PLACE OF DEATH:

(a) County Shelby
(b) City or town Rural Bethel Sup
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Clarence D. Allen

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

4. Sex m 5. Color of w race _____ 6. (a) Single, widowed, married, divorced _____

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

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 55 Months 3 Days 2 If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country) no

10. Usual occupation _____

11. Industry or business _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Dec 25 45 (b) Quith Joyce
(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 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? _____

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

38745