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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

40891  
State File No.

FILED JAN 14 1946

State File No. 40891

Registration District No. 64

Primary Registration District No. 4110

Registrar's No. 77

1. PLACE OF DEATH:

(a) County Andrew  
 (b) City or town Salisbury  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: none  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution no (Specify whether  
 In this community lifetime years, months or days)

3. (a) PRINT FULL NAME James Robert Allen  
 3. (b) If veteran name war no  
 3. (c) Social Security No. no

4. Sex male 5. Color or race white  
 6. (a) Single, widowed, married, divorced married  
 6. (b) Name of husband or wife Julia Broadbent  
 6. (c) Age of husband or wife if alive 82 years  
 7. Birth date of deceased June 2 1855  
 (Month) (Day) (Year)

8. AGE: Years 90 Months 6 Days 3  
 If less than one day hr. min.

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

10. Usual occupation Farming

11. Industry or business Farming

MOTHER FATHER  
 12. Name John Allen  
 13. Birthplace ky  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Elizabeth Hayes  
 15. Birthplace Mo  
 (City, town, or county) (State or foreign country)

16. (a) Informant Roger C. Hanson  
 (b) Address 3717 Paseo - Kansas City Mo

17. (a) burial (b) Date thereof 12-7-45  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Hope Cemetery  
 18. (a) Signature of funeral director Wesley Thompson  
 (b) Address Madison Mo

19. (a) 12/7/45 (b) W. H. Hanson MD  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Chariton  
 (c) City or town Salisbury  
 (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 Dec 5 day 5 year 1945 hour 12 minute 0 M.  
 21. I hereby certify that I attended the deceased from May 2 1945 to Dec 5 1945;  
 that I last saw him alive on Dec 4 1945;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis Duration 20 min

Due to Coronary Sclerosis ?

Due to

Other conditions Fracture of right hip 7 mo.  
 (Include pregnancy within 3 months of death)

Major findings: Of operations — Of autopsy —  
 ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED  
 PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 21

(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

Signature J. L. Hanna (M.D. or other) MD  
 Address Salisbury Mo Date signed Dec 7, 1945

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

1410

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 1-1-46

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**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 Mrs. Freda Thompson

Licensed Embalmer No. 3282

P. O. Address Midway, 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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Jan 77  
Registrar's No. 77

Registration District No. 64 Primary Registration District No. 4112

1. PLACE OF DEATH:  
(a) County Chariton  
(b) City or town Salisbury  
(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 (Specify whether \_\_\_\_\_)  
3. (a) PRINT FULL NAME James P. Allen  
3. (b) If veteran, name war 1 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased June 2 (Month) (Day) (Year)

8. AGE: Years 90 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 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) (Place: burial or cremation)

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (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 Sept Day \_\_\_\_\_ Year 1945 Hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death Accident - tripod up, leg - at home Sept 25, 1945 - fracture of left radius - not working  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
1860's  
18  
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) Accident  
(b) Date of occurrence March 25, 1945  
(c) Where did injury occur? at home (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? at home  
While at work? no (Specify type of place) (e) Means of injury fracture of right hip  
23. Signature F. L. Thomas (M. D. or other) MD  
Address Salisbury Mo Date signed 1-16-46

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

40891