

DEPARTMENT OF COMMERCE THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF THE CENSUS
FILED JAN 15 1946 STANDARD CERTIFICATE OF DEATH

40917

State File No. _____
Registrar's No. 149

Registration District No. 71 Primary Registration District No. 5287

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

1. PLACE OF DEATH:
(a) County Polay
(b) City or town Rural Fishing River
(c) Name of hospital or institution: Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 60 years
In this community 60 years
years, months or days

3. (a) PRINT FULL NAME SARAH EMMA ALLEN
3. (b) If veteran, name war none
3. (c) Social Security No. none

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced in dom?
6. (b) Name of husband or wife George Allen
6. (c) Age of husband or wife if alive 19-1868
7. Birth date of deceased Feb 19-1868
(Month) (Day) (Year)

8. AGE: Years 77 Months 9 Days 17
If less than one day hr. min.

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

10. Usual occupation Home Keeper

11. Industry or business ✓

12. Name Anderson Poe

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

14. Maiden name Nancy Adams

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

16. (a) Informant Mrs. J. J. Groves
(b) Address Rt 13 Liberty Mo

17. (a) Burial (b) Date thereof Dec 8 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Missouri City Mo

18. (a) Signature of funeral director Caroline Butchings
(b) Address Liberty Mo

19. (a) 12/10/45 (b) Caroline Butchings
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Polay 24
(c) City or town Missouri City Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec. day 6
year 1945 hour 7 minute 10 P. M.

21. I hereby certify that I attended the deceased from July 7 1945 to Dec 6 1945
that I last saw her alive on Dec 6 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Diffuse Nephritis
Due to General Arteriosclerosis

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

Major findings: Of operations _____
Of autopsy 1318

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 Quinton Mally (M. D. or other) MD
Address Liberty Mo Date signed 12-7-45

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

1414

RECEIVED

District Health Officer No. 8

District File Number

Date Filed 1-14-46

JAN 16 1946

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 Edgar Archer

Licensed Embalmer No. 3311

P. O. Address Liberty, 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.