

FILED FEB 11 1946

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 48

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2713 Doniphan
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 45 years
(Specify whether years, months or days)
In this community 45 years

3. (a) PRINT FULL NAME

Floyd Allen

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
7. Birth date of deceased April 14 1869
(Month) (Day) (Year)

8. AGE: Years 76 Months 8 Days 26
If less than one day hr. min.

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

10. Usual occupation Clerk - R.I. R.R.Co.

11. Industry or business

12. Name Edgar L. Allen
13. Birthplace — N.Y.
(City, town, or county) (State or foreign country)
14. Maiden name Eliza Risk
15. Birthplace Oregon Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Edna Allen
(b) Address St. Joseph Mo.

17. (a) Burial (b) Date thereof 1-12-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memo. Park Cem

18. (a) Signature of funeral director ELEMAN & SON, INC.

(b) Address ST. JOSEPH MO.

19. (a) Jan. 14, 1946 (b) Edgar Allen
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 2713 Doniphan
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 10
year 1946 hour 12 minute 07 A.M.

21. I hereby certify that I attended the deceased from Dec 29 1945 to Jan 10 1946
that I last saw him alive on Jan 9 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
(artery) Duration 12 days

Due to Arterio Sclerosis no factor

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations g7w
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?

(Specify type of place) While at work? (e) Means of injury

23. Signature John M. Misker (M. D. or other)
Address 1095 No. 8th St. Joseph Date signed 1/11/46

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.