

FILED APR 10 1946

Registration District No. **42**

Primary Registration District No. **1000**

Registrar's No. **378**

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:
1812 Felix
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. **26 yrs.**
(Specify whether years, months or days)
In this community **26 yrs.**

3. (a) PRINT FULL NAME

JOHN H ALLEN

3. (b) If veteran,

name war **NONE**

3. (c) Social Security

No. **493-18-4698**

4. Sex **Male** 21
5. Color or race **NEGRO**

6. (a) Single, widowed, married, divorced **divorced**

6. (b) Name of husband or wife **LEONARD ALLEN**

6. (c) Age of husband or wife if alive **DECEASED** years

7. Birth date of deceased **April 18 1877**
(Month) (Day) (Year)

8. AGE: Years **68** Months **11** Days **5**
If less than one day hr. min.

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

10. Usual occupation **Train Porter**

11. Industry or business **NONE**

12. Name **JOHN ALLEN**

13. Birthplace **Richmond Missouri**
(City, town, or county) (State or foreign country)

14. Maiden name **BETSY CANADA**

15. Birthplace **UNK. OWN Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **JAMES ALLEN**

(b) Address **2206 SYLVANIA ST.**

17. (a) **Burial** (b) Date thereof **MAR 29 1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **ASHLAND**

18. (a) Signature of funeral director **Beatrice Gray**

(b) Address **812 Pacific St**

19. (a) **April 3, 1946** (b) **Off. Hallmark**
(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. **1812 FELIX**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** Day **23** Year **1946** hour **9** minute **30 P.**

21. I hereby certify that I attended the deceased from **21 March** to **23 March** 19**46**
that I last saw him alive on **23 March** and that death occurred on the date and hour stated above.

Immediate cause of death **Cancer** Duration **3 mos +**
Intestinal

Due to **Senility** **6 mos**

Due to **46**

Other conditions (Include pregnancy within 3 months of death)

Major findings: **Cancer 7 Abdomen**

Of operations **46** Of autopsy **46**

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 **Off. Hallmark** (M. D. **25 Mar 46**)
Address **St. Joseph, Mo** Date signed **25 Mar 46**

JUN 18 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.....

Licensed Embalmer No. 4238

P. O. Address St. Joseph 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.