S. No. 2
I—8-43
5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 10178

FILED APR 3 1946

Registration District No. 23

Primary Registration District No. 5812

Registrar's No.

1. PLACE OF DEATH:
(a) County Montgomery
(b) City or town Bellflower Mo R.F.D.
(If outside city or town limits, write "RURAL" and name of township)
(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 ✓ (Specify whether
In this community 6 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Montgomery
(c) City or town Bellflower Mo R.F.D.
(If outside city or town limits, write "RURAL")
(d) Street No. Gamma
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME John Allen

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male | 5. Color or race White | 6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife Deceased

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

7. Birth date of deceased Sept- 7 -1850 (Month) (Day) (Year)

8. AGE: Years 95 | Months 5 | Days 21 | If less than one day hr. min.

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

10. Usual occupation Ret Farmer

11. Industry or business General Duties

FATHER
12. Name John Allen
13. Birthplace New York (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Ruth Hadlock
15. Birthplace Patosia Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Jim Earnest
(b) Address Bellflower Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-2-1946 (Month) (Day) (Year)
(c) Place: burial or cremation St Anthonys Sullivan

18. (a) Signature of funeral director Claud A Jones
(b) Address Bellflower Mo

19. (a) Mar -1- 46 (Date received local registrar) (b) Jos Chapman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 28 year 1946 hour 2 00 minute a M.

21. I hereby certify that I attended the deceased from Feb. 24, 1946, to Feb 28, 1946, that I last saw him alive on Feb 27, 1946; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Bronchial Asthma & Chronic Myocarditis	4 days
Due to Senility & Clr Nephritis	20 year
Due to Acute Urinary Retention	1 day
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? No
While at work? (Specify type of place) (e) Means of injury

23. Signature E. T. Anderson M.D. (M. D. or other) M.D.
Address Montgomery City Mo Date signed 3/1/46

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 4-4-46

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.