

FILED MAR 7 8 1946

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County Shelby
(b) City or town Shelbina
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Simpson Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Two Years
(Specify whether
In this community 84 years
years, months or days)

3. (a) PRINT FULL NAME Mariam Hill Allen
(b) If veteran, name war. 3. (c) Social Security No.

4. Sex W F 5. Color or race W
6. (a) Single, widowed, married, divorced widow
6. (b) Name of husband or wife John H. Allen
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Oct 16 1861
(Month) (Day) (Year)

8. AGE: Years 84 Months 3 Days 3 If less than one day hr. min.

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

10. Usual occupation housewife

11. Industry or business

12. Name John Patterson
13. Birthplace Virginia
(City, town, or county) (State or foreign country)
14. Maiden name Martha Beard
15. Birthplace Augusta Co Virginia
(City, town, or county) (State or foreign country)

16. (a) Informant Chas. B. Allen
(b) Address 1624 Locust St. Denver, Colo.
burial
17. (a) (Burial, cremation, or removal) (b) Date thereof I 21 46
(Month) (Day) (Year)
(c) Place: burial or cremation Shelbina Mo

18. (a) Signature of funeral director E. Hayen
(b) Address Shelbina Mo
19. (a) Mar. 4 46 (b) Ruth Joerner
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Shelby
(c) City or town Shelbina Mo
(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 Jan day 19
year 1946 hour 7 minute A.M.

21. I hereby certify that I attended the deceased from Nov 23
1943, to Jan 19, 1946
that I last saw her alive on Jan 19, 1946
and that death occurred on the date and hour stated above.
Immediate cause of death apoplexy
Duration 20 hr

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

Major findings:
Of operations
Of autopsy

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 J. R. Simpson (M.D. or other) DO
Address Shelbina Mo Date signed Feb 2 - 46

OCT 1 1946

RECEIVED

District Health Officer No. 10

District File Number 3-46-452

Date Filed MAR 13 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.....

E. Hayer

Licensed Embalmer No. 1487

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.