

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22645

State File No.

Registrar's No.

FILED JUL 18 1946

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County Bates
(b) City or town Butler Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Butler Memorial Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME William Earl Allen

3. (b) If veteran, name war X 3. (c) Social Security No. X

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

6. (b) Name of husband or wife Rosa M. 6. (c) Age of husband or wife if alive 53 years

7. Birth date of deceased. Sept 22 1895
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
50 9 7 hr. min.

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

10. Usual occupation Farmer

11. Industry or business

12. Name William Henry Allen
13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)
14. Maiden name Minnie Hard
15. Birthplace Bates County Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Rosa M. Allen

(b) Address Adrian Mo.

17. (a) Burial (b) Date thereof 7-1-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Scott Cemetery

18. (a) Signature of funeral director Carroll & Son

(b) Address Adrian Mo.

19. (a) July 1-46 (b) Handel Perry
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Bates 7
(c) City or town Rural-Elkhart Twp. 9
(If outside city or town limits, write "RURAL")
(d) Street No. 5
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 29
year 1946 hour 6 minute 10 A. M.

21. I hereby certify that I attended the deceased from past 4 yrs
1946 to June 1946
that I last saw him alive on June 28 1946
and that death occurred on the date and hour stated above

Immediate cause of death Cerebral Palsy Duration

by rupture

Due to Cerebral Palsy

Due to 1338

Other conditions per hils. Suppression

(Include pregnancy within 9 months of death)

Major findings:
Of operations

Of autopsy none

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 E. E. Pherson (M. D. or other)

Address Adrian Mo. Date signed 6-29-46

SUL 7 4 1948

License No. 7.
6-46-234
Date Filed 7-17-46

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. 3658

P. O. Address

Adrian 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.