

DEPARTMENT OF COMMERCE THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF THE CENSUS
FILED AUG 1 1946 STANDARD CERTIFICATE OF DEATH

24289

State File No. _____

Registration District No. 209

Primary Registration District No. 3043

Registrar's No. 206

1. PLACE OF DEATH:

(a) County Pike Marion
(b) City or town Hazel
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Elizabeth Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 weeks
(Specify whether years, months or days) 63 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pike 82
(c) City or town Freshford 11
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) 1
(e) Citizen of foreign country? no (Yes or No) 1
If yes, name country _____

3. (a) PRINT FULL NAME ASA CLARK ALLEN

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

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married, divorced 1
6. (b) Name of husband or wife Josie Allen 6. (c) Age of husband or wife if alive 64 years
7. Birth date of deceased. Jan 17 1866
(Month) (Day) (Year)

8. AGE: Years 80 Months 4 Days 22 If less than one day _____ hr. _____ min.

9. Birthplace Kenderhook Mo Ill 1
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER
12. Name Asa Allen
13. Birthplace Illinois 1
(City, town, or county) (State or foreign country)
14. Maiden name Mary Kimm
15. Birthplace unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Asa Josie Allen 1

(b) Address Freshford, Mo

17. (a) Burial (b) Date thereof June 11 46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Freshford, Mo

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

(b) Address Freshford, Mo

19. (a) 6-10-46 (b) Dr. E. M. Lucke
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 9
year 1946 hour 8:30 minute _____ P. M.
21. I hereby certify that I attended the deceased from 6-1-46 to 6-9-46
19____ to 19____
that I last saw him alive on 6-9-46
and that death occurred on the date and hour stated above.

Immediate cause of death Chr myocarditis
Due to _____
Due to 131

Other conditions Chr nephritis
(Include pregnancy within 3 months of death)

Major findings: Hypertrophied prostate
Of operations _____
Of autopsy _____
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 _____ (b) Means of injury no
23. Signature [Signature] (M. D. or other) _____
Address [Address] Date signed 6/10/46

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

4
3
4

20142

189

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

Joe Fields Negron

Licensed Embalmer No.

4093

P. O. Address

Frankford, 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.