

FILED JUL 22 1946

Registration District No. 548

Primary Registration District No. 4173

Registrar's No. 8

1. PLACE OF DEATH:

(a) County Sullivan
(b) City or town Humphreys Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: -
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution - (Specify whether years, months or days)

3. (a) PRINT FULL NAME RAYMOND ORA ALLEN

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

4. Sex M D 5. Color or race Wht 6. (a) Single, widowed, married, divorced M 1
6. (b) Name of husband or wife Mattie Allen 6. (c) Age of husband or wife if alive 71 years
7. Birth date of deceased June 27 1875
(Month) (Day) (Year)

8. AGE: Years 70 Months 11 Days 11 If less than one day hr. min.

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

10. Usual occupation Farming

11. Industry or business

12. Name Thomas Allen
13. Birthplace England (City, town, or county) (State or foreign country)
14. Maiden name Eliza Swank
15. Birthplace Ohio (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mattie Allen

(b) Address Humphreys Mo R.F.D.

17. (a) Burial (b) Date thereof 6-10-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Humphreys cem.

18. (a) Signature of funeral director Ox Payne & Son
(b) Address Galva Mo

19. (a) June 20 1946 (b) Berta Caldwell
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 1st
year 1946 hour 3 minute P. M.

21. I hereby certify that I attended the deceased from June 1st to June 7th 1946
that I last saw him alive on June 7th 1946
and that death occurred on the date and hour stated above.

Immediate cause of death

Cardiac failure

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations None

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?

While at work? (Specify type of place) (e) Means of injury

23. Signature Y. S. Dale (M. D. or other)

Address Newtown, Mo. Date signed 6/17/46

RECEIVED

District Health Officer No. 10

District File Number 7-46-1410

Date Filed JUL-19-1946

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.....

P. R. Payne Jr

Licensed Embalmer No. 3400

P. O. Address Galt

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.