S. No. 2
M—8-43
S-17-39
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

FILED SEP 23 1946

State File No. 32382

Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 153

1. PLACE OF DEATH:
(a) County SALINE
(b) City or town MARSHALL (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: FITZGIBEN Hospital 0 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 DAYS (Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County SALINE 97
(c) City or town MARSHALL 1 (If outside city or town limits, write "RURAL")
(d) Street No. 2 (If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No) If yes, name country

3. (a) PRINT FULL NAME GEORGE BRYANT ALLENDER
3. (b) If veteran, name war NO
3. (c) Social Security No. 494-12-4127

4. Sex MALE
5. Color or race WHITE
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife FRANCIS ALLENDER
6. (c) Age of husband or wife if alive 43 years
7. Birth date of deceased NOVEMBER (Month) 5 (Day) 1897 (Year)

8. AGE: Years 48 | Months 10 | Days 3 | If less than one day ...hr. ...min.

9. Birthplace HIGGENSVILLE (City, town, or county) MISSOURI (State or foreign country)
10. Usual occupation INSPECTOR PRATT+WHITNEY
11. Industry or business
12. FATHER Name GEORGE WASHINGTON ALLENDER
13. FATHER Birthplace UNKNOWN (City, town, or county) a (State or foreign country)
14. MOTHER Maiden name LIZZIE DAVIDSON
15. MOTHER Birthplace UNKNOWN (City, town, or county) 9 (State or foreign country)
16. (a) Informant MRS FRANCIS ALLENDER
(b) Address MAYVIEW Mo
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPTEMBER 10 1946 (Month) (Day) (Year)
(c) Place: burial or cremation HIGGENSVILLE City Cemetery
18. (a) Signature of funeral director DWANE EKINS
(b) Address SEDALIA MO
19. (a) 9-8-46 (Date received by local registrar) (b) Mrs T Burkhardt (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPTEMBER day 8 year 1946 hour 1 minute 40 P M.
21. I hereby certify that I attended the deceased from Sept 1, 1946 to Sept 8, 1946 that I last saw him alive on Sept 8, 1946 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Lobar Pneumonia	48 hrs.
Due to: Aortic Aneurism	Unk
Due to: 1	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations: 168	
Of autopsy: None	

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? (Specify type of place) While at work? (e) Means of injury 0
23. Signature [illegible] (M.D. or other) Address Marshall Mo Date signed 9/9/46

a-14 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number.....
Date Filed 9-21-46

SEP 27 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 Duane Ewing

Licensed Embalmer No. 3844

P. O. Address Sedalia 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.