

FILED FEB 5 1947
Registration District No. **38**

Primary Registration District No. **3.006**

1. PLACE OF DEATH:

(a) County **Boone**
(b) City or town **Columbia Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Dr. Granau Convelesant Home 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **6 months**
(Specify whether years, months or days)
In this community **6 months**

3. (a) PRINT FULL NAME **Mary Eliza Allen**

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

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Joshua Terrill Allen**
6. (c) Age of husband or wife if alive **----** years
7. Birth date of deceased **April 21 1847**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
99 9 9 hr. min.

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

10. Usual occupation **At home**

11. Industry or business

12. Name **Thomas Howard**
13. Birthplace **Kentucky**
(City, town, or county) (State or foreign country)
14. Maiden name **Elizabeth Shields**
15. Birthplace **Howard County Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Harley Davis**
(b) Address **Fayette, Missouri**
17. (a) Removal & Burial Date thereof **2/2/47**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Armstrong Mo. Cemetery**

18. (a) Signature of funeral director **Ralph A. Carr**
(b) Address **Fayette, Missouri**
19. (a) **1-31-47** (b) **Mrs R E Palmer**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan.** day **30**
year **1947** hour **9:45** minute **A.** M.

21. I hereby certify that I attended the deceased from **Sept 8**
1946 to **January 30, 1947**
that I last saw her alive on **Jan 30th**, 1947,
and that death occurred on the date and hour stated above.

Immediate cause of death **Old age**
Due to

Due to **Senile failure of all vital metabolic functions**
Other conditions **none**
(Include pregnancy within 3 months of death)

Major findings:
Of operations **16-2-13**
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 (c) Means of injury
23. Signature **Lee H. Granau** (M. D. or other)
Address **1408 University Ave** Date signed **1/31/47**

RECEIVED
District Health Officer No. 9,
District File Number 2-4-47
Date Filed

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, Robert

_____, Registered Apprentice No. _____,
working under my personal supervision.

Signed Robert A. Carr
Licensed Embalmer No. 3340
P. O. Address Gayles 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.