

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20108

State File No. _____

FILED JUL 14 1947

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 823

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Missouri Methodist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 hours
(Specify whether years, months or days)
In this community 6 hours

3. (a) PRINT FULL NAME Emma Allen

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife E. D. Allen 6. (c) Age of husband or wife if alive — years
7. Birth date of deceased Feb. 12, 1861
(Month) (Day) (Year)

8. AGE: Years 86 Months 4 Days 21 If less than one day hr. min.

9. Birthplace Mills County Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business In the home

12. Name Thomas Connor

13. Birthplace Connorsville Ind.
(City, town, or county) (State or foreign country)

14. Maiden name Phoebe Gilliland

15. Birthplace Connorsville Ind.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. W. H. Campbell

(b) Address Oregon, Mo.

17. (a) Burial (b) Date thereof July 5, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Liberty

18. (a) Signature of funeral director Wilber L. Schooner

(b) Address Craig, Mo.

19. (a) 7-7-47 (b) E. B. Jenkins
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Holt 44
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 4 miles Northeast of Craig
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 3
year 47 hour 7 minute P. M.

21. I hereby certify that I attended the deceased from July 3, 1947 to July 3, 1947;
that I last saw her alive on July 3, 1947;
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Embolism Duration Sudden
Shock following
fracture R. hip 1 day

Due to Chronic valvular heart disease

Due to Chronic arthritis yrs.

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations: g6, 14, 18

Of autopsy No 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) Accident

(b) Date of occurrence July 3, 1947 44

(c) Where did injury occur? Craig, Holt, Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
In home

While at work? No (Specify type of place)

(e) Means of injury fracture hip

23. Signature H. S. Sauran (M. D. or other) —

Address St. Joseph Mo Date signed 7-4-47

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.....

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

Signed *Wilber L. Schooler*.....

Licensed Embalmer No. *3997*.....

P. O. Address *Craig, 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.