

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30593

State File No. _____

FILED OCT 8 1947
33

Registration District No. _____

Primary Registration District No. 3010

Registrar's No. 299

1. PLACE OF DEATH:

(a) County Cape Girardeau
(b) City or town Cape Girardeau
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Francis Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 Months
(Specify whether
In this community 2 Months
years, months or days)

3. (a) PRINT FULL NAME Curtis Lehman Allgier

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

4. Sex Male 5. Color or race W. 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Louella Allgier 6. (c) Age of husband or wife if alive 26 years
7. Birth date of deceased May 11 1919
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
28 4 14 hr. min.

9. Birthplace Risco Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Merchant

11. Industry or business Banking

MOTHER FATHER { 12. Name W. M. Allgier
13. Birthplace Ironton Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Etha Depew
15. Birthplace Ironton Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant W. M. Allgier
(b) Address Risco, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-28-47
(Month) (Day) (Year)

(c) Place: burial or cremation Malden Memorial Park

18. (a) Signature of funeral director Day Funeral Home

(b) Address Malden, Missouri

19. (a) 9-30-1947 (b) C. G. Summers
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dunklin
(c) City or town Malden
(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 9 day 25
year 1947 hour 12 minute 50 P.M.

21. I hereby certify that I attended the deceased from 18-20 to 9-25, 1947.
that I last saw him alive on 9-25 and that death occurred on the date and hour stated above. 1947.

Immediate cause of death -
1 - Cardiac failure
Secondary to
Due to ① - Sept coronary occlusion
Due to ② Aortic stenosis
Other conditions (probably rheumatic)
(Include pregnancy within 3 months of death) in origin

Major findings:
Of operations Stenosis of aorta
Of autopsy valve
Coronary occlusion

22. If death was due to external causes, in the following: (Sept)

(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 Alfred M. Esten (M. D. or other) MD
Address Jackson, Mo. Date signed 9-28-47

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

NOV 18 1948
JAN 28 1949

SEP 28 1950

RECEIVED

Health Officer No. 4
File Number 1047-12
Filed 10-6-47

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.....

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

Signed.....

J. D. Schuman
- - - - -

Licensed Embalmer No. 4086

P. O. Address Malden

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.