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MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 33663

FILED OCT 24 1947

Registrar's No. 270

Registration District No. 3006 Primary Registration District No. 3006

1. PLACE OF DEATH:

(a) County Boone

(b) City or town Columbia
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
None 900 Conley
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 62 yrs.
(Specify whether years, months or days)

In this community 62 yrs.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Boone 10

(c) City or town Columbia 2
(If outside city or town limits, write "RURAL") 4

(d) Street No. 900 Conley 0
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country.....

3. (a) PRINT FULL NAME PRISCILLA S. ALLEN

3. (b) If veteran, name war.....

3. (c) Social Security No.

4. Sex F / 5. Color or race W

6. (a) Single, widowed, married, divorced W 2

6. (b) Name of husband or wife E.A. Allen

6. (c) Age of husband or wife if alive, dead 1850 years
(Month) (Day) (Year)

7. Birth date of deceased 12
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	96	10	2hr.min.

9. Birthplace Edenton N.C.
(City, town, or county) (State or foreign country)

10. Usual occupation Home

11. Industry or business.....

12. Name John M. Saunders 9

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

14. Maiden name Sarah Armistead Thorps

15. Birthplace Norfolk Va.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. H.M. Belden

(b) Address 811 Virginia Columbia Mo.

17. (a) Burial (b) Date thereof 10 16 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Columbia Cem.

18. (a) Signature of funeral director Parker Funeral Service

(b) Address 18 N 10 Columbia Mo.

19. (a) 10-18-47 (b) Mrs. R.E. Palmer
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 14
year 1947 hour 11:00 minute..... AM.

21. I hereby certify that I attended the deceased from Jan
1947 to Oct 14 1947
that I last saw her alive on Oct 13 1947
and that death occurred on the date and hour stated above. Duration

Immediate cause of death Cerebral thrombosis

Due to cerebral arteries - sclerosis

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings: 43 A

Of operations.....

Of autopsy.....

PHYSICIAN

Underline the cause of 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?.....
(Specify type of work) (Cause of injury)

23. Signature [Signature] (M. D. or other)

Address Columbia Mo Date signed 10/17/47

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

MOTHER FATHER

Date Filed 10-23-47

District File Number

District Health Officer No. 9

RECEIVED

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 Tom M. Harg

Licensed Embalmer No. 4067

P. O. Address Columbia, 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.