

1-17-47
1-17-39

State File No.
Registrar's No.

FILED DEC 26 1947
Registration District No.

Primary Registration District No. 4386

1. PLACE OF DEATH:

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Oregon 75
(c) City or town Thayer
(If outside city or town limits, write "RURAL")
(d) Street No..... (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Haston Allen
3. (b) If veteran, name war..... 3. (c) Social Security No.

'MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov. day 29
year 1947 hour 5 minute 05 A. M.

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Ludie C. Allen 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased August 30 1876
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from July 1946 to Nov 29 1947
that I last saw him alive on Nov 29 1947
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
71	2	29 hr. min.

Immediate cause of death Coronary Heart Disease
Diabetes Mellitus
Due to.....
Due to.....

Duration

1 1/2 years

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

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

10. Usual occupation Retired

Major findings: 61

11. Industry or business.....

12. Name N. B. Allen

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

14. Maiden name Emma I. Allen

15. Birthplace Dade County Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. E. M. Daniel

(b) Address Mammoth Spring, Ark.

17. (a) Burial (b) Date thereof 12/1/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Thayer Cem.

18. (a) Signature of funeral director Selena Carter

(b) Address Thayer, Mo.

19. (a) 12-18-47 (b) Edith Corass
(Date received local registrar) (Registrar's signature)

Of operations.....

Of autopsy.....

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.....

23. Signature DW Cooper MD (M. D. or other)

Address Thayer Mo Date signed 12-16-47

PHYSICIAN

Underline the cause of which death should be charged statistically.

Cooper

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

MOTHER FATHER

RECEIVED

District Health Officer No. 5;

District File No. 1247720

Date Filed 12-20-47

DEC 29 1947

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan
Registrar's No. _____

Registration District No. 254 Primary Registration District No. 4386

1. PLACE OF DEATH:

(a) County Oregon
(b) City or town Thayer
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
in this community _____
years, months or days)

3. (a) PRINT FULL NAME

Hasten Allen

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m 5. Color or race w

6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Aug 30
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Day _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country) MO

10. Usual occupation Retired

11. Industry or business _____

MOTHER FATHER {
12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day 29
year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____

Due to _____

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

Major findings:

Of operations _____

Of autopsy _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

STANDARD CERTIFICATE OF DEATH

42524