

# THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

3706

State File No. ....

No. 300  
10.48

FILED FEB 15 1949

BIRTH NO. ....		REG. DIST. NO. <u>328</u>		PRIMARY REG. DIST. NO. <u>3073</u>		Registrar's No. <u>4</u>	
1. PLACE OF DEATH a. COUNTY <u>Scott</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Scott</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Chaffee</u>		c. LENGTH OF STAY (in this place) <u>36 years</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Chaffee</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>- /</u>				d. STREET ADDRESS (If rural, give location) <u>8</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Minnie</u>		b. (Middle) <u>Estelle</u>		c. (Last) <u>Allen</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 31 1949</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>March 19 1895</u>	
9. AGE (In years last birthday) <u>53</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Thebes, Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>David Buster</u>		13b. MOTHER'S MAIDEN NAME <u>Georgia Brush</u>		14. NAME OF HUSBAND OR WIFE <u>Ralph H. Allen</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Miss Ethel Clapp Chaffee, Mo</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>(1) Regenerative vascular</u> <u>(2) Diastolic &amp; diastolic</u> DUE TO (c) <u>Hypertension</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>(3) Reduced Renal function</u>					INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION <u>✓</u>		19b. MAJOR FINDINGS OF OPERATION <u>✓</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>✓</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>✓</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>✓</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>✓</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>✓</u>			
22. I hereby certify that I attended the deceased from <u>December 16, 1946</u> , to <u>January 15, 1949</u> , that I last saw the deceased alive on <u>Jan 15, 1949</u> , and that death occurred at <u>11:35 P.M.</u> , from the cause and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Walter M. Estes M.D.</u>				23b. ADDRESS <u>225 N. Main St. Chaffee, Mo</u>		23c. DATE SIGNED <u>Feb 2, 1949</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		24b. DATE <u>2-3-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Old Thebes</u>		24d. LOCATION (City, town, or county) (State) <u>Thebes, Ill.</u>	
DATE REC'D BY LOCAL REG. <u>2/8/49</u>		REGISTRAR'S SIGNATURE <u>W.B. MacGregor</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Bisplinghoff Funeral Home Chaffee, Mo</u>			

(Licensed Embalmers Statement on Reverse Side)

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

RECEIVED

District Health Office No. 2

District File Number 249-247

Date Filed 2-14-49

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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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*Mamie B. [Signature]*

Licensed Embalmer No. 2242

P. O. Address Chaffee, 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.