

FILED SEP 12 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27545

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

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. <u>4370</u>		Registrar's No. <u>204</u>	
1. PLACE OF DEATH a. COUNTY <u>Nodaway</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Iowa</u> b. COUNTY <u>Page</u>			
b. CITY OR TOWN <u>Clearmont</u>		c. LENGTH OF STAY (In this place) <u>3 Mo.</u>		c. CITY OR TOWN <u>Braddyville</u>		13 <u>13</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Wallin Nursing Home</u>				d. STREET ADDRESS (If rural, give location) <u>0</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>EMMA</u> b. (Middle) _____ c. (Last) <u>ALLEN</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>August 24-1949</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>Mar-27-1861</u>	
9. AGE (In years) <u>88</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>St. Louis, Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME (First Name) <u>Rembar</u>		13b. MOTHER'S MAIDEN NAME <u>Not known</u>		14. NAME OF HUSBAND OR WIFE <u>Ralph W. Allen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>John Wambler</u> ADDRESS _____			
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>Cardio-renal failure</u> ANTECEDENT CAUSES DUE TO (b) _____ DUE TO (c) <u>Senility.</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Bedfast urinary stasis.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u> <u>42X</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>August 20, 1949</u> , to <u>August 23, 1949</u> , that I last saw the deceased alive on <u>August 23, 1949</u> , and that death occurred at <u>6:45 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Describe or Title) <u>Marvin Ford</u>				23b. ADDRESS <u>Elmo Mo</u>		23c. DATE SIGNED <u>Aug 26 1949</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Aug-24-1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Clarinda Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>Clarinda, Iowa</u>	
DATE REC'D BY LOCAL REG. <u>9-3-49</u>		REGISTRAR'S SIGNATURE <u>Bess Holt</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Leslie D. Walker</u>		ADDRESS <u>Clarinda Ia</u>	

