

FILED FEB 19 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 7252

BIRTH NO. _____		REG. DIST. NO. 347		PRIMARY REG. DIST. NO. 6162		Registrar's No. 1	
1. PLACE OF DEATH a. COUNTY Stone				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Stone			
b. CITY OR TOWN Reeds Spring		c. LENGTH OF STAY (in this place) 7 yrs		c. CITY (If outside corporate limits, write RURAL and give township) Reeds Spring Mo		d. STREET ADDRESS (If rural, give location) 10401	
d. FULL NAME OF HOSPITAL OR INSTITUTION				d. STREET ADDRESS (If rural, give location) 10401			
3. NAME OF DECEASED (Type or Print) a. (First) Eliza		b. (Middle) JANE		c. (Last) ALLEN		4. DATE OF DEATH (Month) (Day) (Year) JAN 2 1951	
5. SEX F		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH NOV 18 1882	
9. AGE (In years last birthday) 68		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Mo. O		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME LOUIS BLAIR		13b. MOTHER'S MAIDEN NAME SARAH ANN WALLEN		14. NAME OF HUSBAND OR WIFE SYLVESTER ALLEN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Earl Allen Reeds Spring Mo			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Mitral Insufficiency ANTECEDENT CAUSES DUE TO (b) Don't know DUE TO (c) Don't know II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. H/OX				INTERVAL BETWEEN ONSET AND DEATH 6 yrs	
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 Jan 1945, to Jan 2, 1951, that I last saw the deceased alive on Dec 30, 1950, and that death occurred at 5 A m., from the causes and on the date stated above.							
23a. SIGNATURE L.S. Humate M.D.		23b. ADDRESS Reeds Spring Mo		23c. DATE SIGNED 1/2/51			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Jan 4 1951		24c. NAME OF CEMETERY OR CREMATORY Valerius Road		24d. LOCATION (City, town, or county) (State) Reeds Spring Mo	
DATE REC'D BY LOCAL REG. Jan 3 - 51		REGISTRAR'S SIGNATURE Lena Murray		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Everett A. Chestnut Helena Mo			

(Licensed Embalmer's Statement on Reverse Side)

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

DIVISION OF HEALTH OF MO.

District No. 5 - Springfield

RECEIVED FEB 15 1934

Dist. File 251-386

Date Filed 2-15-34

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.

Signed Everett J. Cheatham

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 8870

P. O. Address Salina, 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.