

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **27443**

FILED AUG 6 - 1953

BIRTH NO. _____		REG. DIST. NO. 339		PRIMARY REG. DIST. NO. 6149		Registrar's No. 14	
1. PLACE OF DEATH a. CITY STODDARD				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY STODDARD			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN DUCKCREEK - RURAL		c. LENGTH OF STAY (in this place) 3 1/2 yrs.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL-DUCKCREEK 1030			
d. FULL NAME OF HOSPITAL OR INSTITUTION 1mi. east & 2mi. south of Fisk				d. STREET ADDRESS (If rural, give location) 1mi. east & 2mi. S. of Fisk			
3. NAME OF DECEASED (Type or Print) a. (First) FLORA b. (Middle) ALLEN c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) 8-2-53				
5. SEX female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2		8. DATE OF BIRTH 1-11-1880	
9. AGE (in years last birthday) 73		10. MONTHS 6		11. BIRTHPLACE (State or foreign country) Ark.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Waits		13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE Charles Allen			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Bland Brooks ADDRESS Fisk 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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Senility ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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 Oct 1952 to Aug 2, 1953 , that I last saw the deceased alive on July 21, 1953 , and that death occurred at 11:45 P.M. , from the causes and on the date stated above.							
23a. SIGNATURE H. H. Keelings Sr. (Degree or title) Dr.				23b. ADDRESS Payco Mo.		23c. DATE SIGNED Aug 3 1953	
24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE 8-3-53		24c. NAME OF CEMETERY OR CREMATORY Blytheville Ark.		24d. LOCATION (City, town, or county) (State) Blytheville Ark.	
DATE REC'D BY LOCAL REG. 8/3/53		REGISTRAR'S SIGNATURE Paul Reed 490		25. FUNERAL DIRECTOR'S SIGNATURE J. C. White ADDRESS Fisk, Mo.			

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

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

Philip J. Casserly

Licensed Embalmer No. *4618*

P. O. Address *Poplar Bluff, 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.