. No. 300
. 10-48

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 7 1953

State File No. 30890

BIRTH NO. _____ REG. DIST. NO. 379 PRIMARY REG. DIST. NO. 6285 Registrar's No. 48

1140 4

1. PLACE OF DEATH
a. COUNTY Wright
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mtn Grove Township
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Ozarks Rest Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo. b. COUNTY Wright
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mtn Grove Mo
d. STREET ADDRESS (If rural, give location) East 18th St. 1140

3. NAME OF DECEASED (Type or Print) a. (First) Mary b. (Middle) Poden c. (Last) Allen

4. DATE OF DEATH (Month) July (Day) 29, (Year) 1953

5. SEX Female

6. COLOR OR RACE W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH July 29, 1866

9. AGE (In years last birthday) 87 IF UNDER 1 YEAR Months 0 Days 0 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY Housekeeper

11. BIRTHPLACE (State or foreign country) Arkansas

12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME W. F. Poden

13b. MOTHER'S MAIDEN NAME Talitha J. Cope

14. NAME OF HUSBAND OR WIFE John L. 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 AND ADDRESS Mr. Garnet Schofield Mtn Grove

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) Congestive Heart Disease — INTERVAL BETWEEN ONSET AND DEATH

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 Fractured hip June 26

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION 4341 F

20. AUTOPSY? YES ☐ NO ☒

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) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 20, 1953, *to* July 29, 1953; *that I last saw the deceased alive on* July 28, 1953, *and that death occurred at* 5:00 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) C. W. Flemming M.D.

23b. ADDRESS Mtn. Grove Mo.

23c. DATE SIGNED 7-30-53

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 7-31-53

24c. NAME OF CEMETERY OR CREMATORY Hillcrest

24d. LOCATION (City, town, or county) (State) Mtn Grove, Mo

DATE REC'D BY LOCAL REG. 8-3-53

REGISTRAR'S SIGNATURE Ab. Ames 348

25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Stobbe-Wendle Mtn Grove

(Licensed Embalmer's Statement on Reverse Side)

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 Frank Grable

Licensed Embalmer No. 4160

P. O. Address Saint Groix, Wis

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.