

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35667**

Reid's
FILED OCT 19 1953

BIRTH NO. _____ REG. DIST. NO. **133** PRIMARY REG. DIST. NO. **3022** Registrar's No. **98**

1. PLACE OF DEATH a. COUNTY Harrison		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Harrison	
b. CITY (If outside corporate limits, write RURAL and give township) Bethany	c. LENGTH OF STAY (In this place) 6 da.	c. CITY (If outside corporate limits, write RURAL and give township) Bethany 0410	
d. FULL NAME OF HOSPITAL OR INSTITUTION Reid Hospital		d. STREET ADDRESS (If rural, give location) A 15th	

3. NAME OF DECEASED (Type or Print) a. (First) Daniel b. (Middle) Walter c. (Last) Allen			4. DATE OF DEATH (Month) (Day) (Year) 10-8-53			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 2-12-1886	9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months 7 Days 26	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (City and State or Foreign Country) Harrison County Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME Calloway Allen	13b. MOTHER'S MAIDEN NAME Margaret Russell	14. NAME OF HUSBAND OR WIFE Minnie Catherine Allen
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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. None	17. INFORMANT'S SIGNATURE OR NAME Viola Lucy New Hampton	ADDRESS New Hampton Mo
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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		INTERVAL BETWEEN ONSET AND DEATH 28 hrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* Intestinal Obstruction		DUE TO (b) Carcinoma of Transverse Colon DUE TO (c)
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 153X	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **8-15**, 19**53** to **10-8**, 19**53**, that I last saw the deceased alive on **10-8-53**, and that death occurred at **4:00 pm.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Gellumt M. Thayer MD	23b. ADDRESS Bethany, Mo	23c. DATE SIGNED 10-12-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10-10-53	24c. NAME OF CEMETERY OR CREMATORY Hobbs	24d. LOCATION (City, town, or county) (State) Eagleville, Mo.
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DATE REC'D BY LOCAL REG. 10/15/53	REGISTRAR'S SIGNATURE Zola Burris	25. FUNERAL DIRECTOR'S SIGNATURE M. H. Lee	ADDRESS Bethany Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

300
48

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

YMBHaw

Licensed Embalmer No. 3899

P. O. Address Bethany - 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.