

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **43614**

No. 300  
10-48

FILED DEC 22 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 209 PRIMARY REG. DIST. NO. 3043 Registrar's No. 425

44  
4

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

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MARION</u> b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>HANNIBAL</u> c. LENGTH OF STAY (In this place) <u>1 Mo.</u> d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>BECKY THATCHER NURSING HOME</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>MARION</u> c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>HANNIBAL</u> <u>0644</u> d. STREET ADDRESS (If rural, give location) <u>1226 GIRARD</u> <u>0</u>	
--	--	--	--

<b>3. NAME OF DECEASED</b> a. (First) <u>MYRTLE</u> (Middle) <u>B.</u> (Last) <u>ALLEN</u> (Type or Print)		<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>12 - 16 - 53</u>	
--	--	---	--

<b>5. SEX</b> <u>FEMALE</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <u>WIDOWED</u>	<b>8. DATE OF BIRTH</b> <u>12-17-1874</u>	<b>9. AGE</b> (In years last birthday) <u>79 1/2</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____
--------------------------------	---	---	--	--

<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>NONE</u>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>NONE</u>	<b>11. BIRTHPLACE</b> (State or foreign country) <u>ILLIOPOLIS, ILLINOIS</u>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>
---	---	---	--

<b>13a. FATHER'S NAME</b> <u>?</u>	<b>13b. MOTHER'S MAIDEN NAME</b> <u>MURTLE GASAWAY</u>	<b>14. NAME OF HUSBAND OR WIFE</b> (Dec) <u>WILLIAM LUTHER ALLEN</u>
---------------------------------------	---	---

<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	<b>16. SOCIAL SECURITY NO.</b> - - -	<b>17. INFORMANT'S SIGNATURE OR NAME</b> ADDRESS <u>MRS. MAY McDANIEL - RUSH, NEW YORK</u>
--	---	---

<b>18. CAUSE OF DEATH</b> 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.	<p align="center"><b>MEDICAL CERTIFICATION</b></p> <b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <u>Cerebral thrombosis, right</u> ANTECEDENT CAUSES DUE TO (b) <u>Left hemiplegia</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) <u>Pneumonia</u> <b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death. <u>Arteriosclerotic heart disease</u>	<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>6 days</u>  <u>6 days</u>  <u>6 days</u>  <u>4 mths</u>
--	---	---

<b>19a. DATE OF OPERATION</b>	<b>19b. MAJOR FINDINGS OF OPERATION</b> <u>493 X</u>	<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>
-------------------------------	---	---

<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)	<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b>
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) m.	<b>21e. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>21f. HOW DID INJURY OCCUR?</b>

**22. I hereby certify that I attended the deceased from 9-21-53, 19, to 12-16-53, 19, that I last saw the deceased alive on 12-16-53, 19, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.**

<b>23a. SIGNATURE</b> (Degree or title) <u>[Signature]</u> M.D.	<b>23b. ADDRESS</b> <u>100 N. Sixth, Hannibal, Mo.</u>	<b>23c. DATE SIGNED</b> <u>12-18-53</u>
--	---	--

<b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>	<b>24b. DATE</b> <u>12-18-53</u>	<b>24c. NAME OF CEMETERY OR CREMATORY</b> <u>GRAND VIEW BURIAL PARK</u>	<b>24d. LOCATION</b> (City, town, or county) (State) <u>HANNIBAL, MISSOURI</u>
---	-------------------------------------	--	---

<b>DATE REC'D BY LOCAL REG.</b> <u>12/18/53</u>	<b>REGISTRAR'S SIGNATURE</b> <u>[Signature]</u> Deputy	<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <u>[Signature]</u> - Hannibal, Mo.
--	---	---

RECEIVED

DEC 21 1953

DEC 21 1953

MARION CO. HEALTH DEPT.

DATE FILED DEC 21 1953

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 Jack Schwart

Licensed Embalmer No. 4800

P. O. Address Hannibal, 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.