

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

10889

State File No. \_\_\_\_\_

No. 300  
10.48

BIRTH DATE FILED MAR 19 1954 REG. DIST. NO. 328 PRIMARY REG. DIST. NO. 3073 Registrar's No. 6

1. PLACE OF DEATH a. COUNTY <u>SCOTT</u>		2. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission) a. STATE <u>MO</u> b. COUNTY <u>SCOTT</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>CHAFFEE</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>CHAFFEE</u>	
c. LENGTH OF STAY (in this place) <u>51 yrs</u>		d. STREET ADDRESS (If rural, give location) <u>FRISCO ST</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>FRISCO ST</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>JOSEPH</u> b. (Middle) <u>FRANCIS</u> c. (Last) <u>ALLWOOD</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>3 7 1954</u>		
---	--	--	---	--	--

5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>M.</u>	8. DATE OF BIRTH <u>MAY 11-1872</u>	9. AGE (In years last birthday) <u>81</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>26</u>	IF UNDER 2 HRS. Hours <u></u> Min. <u></u>
-----------------	---------------------------	--	-------------------------------------	---	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RAILROAD</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>SECTION WORK</u>	11. BIRTHPLACE (State or foreign country) <u>GRAVILLE ILL</u>	12. CITIZEN OF WHAT COUNTRY? <u>✓</u>
---	---	---	---------------------------------------

13a. FATHER'S NAME <u>FRANCIS ALLWOOD</u>	13b. MOTHER'S MAIDEN NAME <u>ELIZA GAUGH</u>	14. NAME OF HUSBAND OR WIFE <u>ROSA ALLWOOD</u>
---	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>✓</u> (If yes, give war or date of service)	16. SOCIAL SECURITY NO. <u>✓</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. J. Allwood-Chaffee Mrs.</u> ADDRESS _____
--	----------------------------------	---

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		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>  <u>12 yrs</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Apoplexy</u>		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Generalized Arterio Sclerosis</u> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Ventral Hernia</u>			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION <u>334 X</u>	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 Dec 19 53 to MAY 7, 19 54 that I last saw the deceased alive on Mar 6, 19 54 and that death occurred at 4 a. m., from the causes and on the date stated above.

23a. SIGNATURE <u>W. O. Turner M.D.</u> (Degree or title)	23b. ADDRESS <u>1400 Chaffee St</u>	23c. DATE SIGNED <u>3/11/54</u>
---	-------------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>3-8-1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>UNION PARK CEM. CHAFFEE.</u>	24d. LOCATION (City, town, or county) (State) <u>MO.</u>
---	---------------------------	--	--

DATE REC'D BY LOCAL REG. <u>3-11-54</u>	REGISTRAR'S SIGNATURE <u>Thos. J. Bejinger</u>	445	25. FUNERAL DIRECTOR'S SIGNATURE <u>Chaffee Mrs.</u> ADDRESS _____
---	--	-----	--

(Issued Embalmers' Statement on Reverse Side)

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

DATE RECEIVED MAR 15 1954

SCOTT CO. HEALTH DEPT.

CO. FILE No. 354-64

MAR 19 1954

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

*C. J. Laberg*

Licensed Embalmer No. 3810

P. O. Address Cape Girardeau 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.