

FILED JUL 26 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 23980

BIRTH NO. _____		REG. DIST. NO. 278	PRIMARY REG. DIST. NO. 3054	Registrar's No. 75
1. PLACE OF DEATH a. COUNTY <u>Pike</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pike</u>		
b. CITY OR TOWN <u>Louisiana</u>		c. LENGTH OF STAY (in this place) <u>5 days</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Frankford</u> 0820	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Pike Co. Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>0</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>JOSEPHINE</u> b. (Middle) <u>CARL</u> c. (Last) <u>ALLEN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>JUNE 30 1954</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>OCT 16 1881</u>	9. AGE (In years last birthday) <u>72</u> # UNDER 1 YEAR _____ # UNDER 1 Mth. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) <u>FRANKFORD - Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>THOMAS CARL ALLISON</u>		13b. MOTHER'S MAIDEN NAME <u>ELIZABETH ALLISON</u>	14. NAME OF HUSBAND OR WIFE <u>ASA ALLEN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>499-012682</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Raymond O. Allen</u> ADDRESS <u>Bowling Green, Mo</u>	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Generalized Adenocarcinoma</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Carcinoma -</u> DUE TO (c) <u>Ovary - ovary</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
19a. DATE OF OPERATION <u>6-29</u>	19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma -</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 <u>2-5, 1954</u> , to <u>6-30, 1954</u> , that I last saw the deceased alive on <u>6-30, 1954</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.				
23a. SIGNATURE <u>Colleen M. M. M.D.</u> (Degree or title)		23b. ADDRESS <u>Louisiana, Mo</u>		23c. DATE SIGNED <u>7-6-54</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>July 3, 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Frankford Mo -</u>	
DATE REC'D BY LOCAL REG. <u>July 7, 1954</u>	REGISTRAR'S SIGNATURE <u>Veronica Callen</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>1374 Fields &amp; Son</u>	ADDRESS <u>Frankford Mo</u>	

(Licensed Embalmer's Statement on Reverse Side)

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 Jose Fields Meyerson

Licensed Embalmer No. 4693

P. O. Address Frankford 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.