

FILED SEP 12 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27171

State File No.

BIRTH NO. <u>58381-55</u>		REG. DIST. NO. <u>274</u>		PRIMARY REG. DIST. NO. <u>3052</u>		Registrar's No. <u>232</u>	
1. PLACE OF DEATH a. COUNTY <u>Pettis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Pettis</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Sedalia</u>		c. LENGTH OF STAY (in this place) <u>36 hrs.</u>		c. CITY OR TOWN <u>Sedalia</u>		d. Is Residence within limits of a city or incorporated town? Yes ☒ No ☐	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Bothwell Hospital</u>				STREET ADDRESS (If rural, give location) <u>244 South Vermont</u> <u>080 1/2</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>MICHAEL</u> b. (Middle) <u>RAY</u> c. (Last) <u>ALLEN</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 2, 1955</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>Aug. 31, 1955</u>	
9. AGE (In years last birthday) <u>1</u> Months <u>1</u> Days <u>12</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during usual waking hours, even if retired) <u>INFANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>*****</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Sedalia, Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13a. FATHER'S NAME <u>Joe Dennis Allen</u>				13b. MOTHER'S MAIDEN NAME <u>Patricia Ann Huffman</u>		14. NAME OF HUSBAND OR WIFE <u>*****</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Joe Dennis Allen, 244 S. Vermont</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, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Anoxia</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Prematurity 38 weeks</u> DUE TO (c) 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 <u>776 X</u>				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) (Min.)		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 <u>Sept 1</u> , 19 <u>55</u> , to <u>Sept 2</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Sept 1</u> , 19 <u>55</u> , and that death occurred at <u>3:55 a.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Elvin L. Lowe M.D.</u>				(Degree or title)		23b. ADDRESS <u>Sedalia, Mo.</u>	
23c. DATE SIGNED <u>9-3-55</u>							
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>9/3/55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Sedalia, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>9-3-55</u>		REGISTRAR'S SIGNATURE <u>Barbara Cora Deputy</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. E. ...</u>		ADDRESS <u>Sedalia, Mo.</u>	

(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.....
Signature of Student Embalmer

Signed *Francis E. Smith*

Licensed Embalmer No. *10*

P. O. Address *Lebanon*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If
to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.