

FILED MAR 12 1956

THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

State File No. 7705

7705

BIRTH NO. _____		REG. DIST. NO. 324		PRIMARY REG. DIST. NO. 3071		Registrar's No. 43	
1. PLACE OF DEATH a. COUNTY <u>Saline</u> b. CITY (If outside corporate limits, write RURAL and give township) <u>Marshall</u> c. LENGTH OF STAY (in this place) <u>4 days</u> d. FULL NAME OF HOSPITAL OR INSTITUTION <u>John Fitzgibbon Memorial Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u> c. CITY OR TOWN <u>Slater</u> d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> e. STREET ADDRESS (If rural, give location) <u>303 S. Emerson</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Maude</u> b. (Middle) <u>Allen</u> c. (Last) <u>Allen</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>4</u> (Year) <u>56</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>		8. DATE OF BIRTH <u>March 11, 1870</u>		9. AGE (In years last birthday) <u>85</u>		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>23</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>0</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13a. FATHER'S NAME <u>John Wilson</u>		13b. MOTHER'S MAIDEN NAME <u>Hulda Ann (unknown)</u>		14. NAME OF HUSBAND OR WIFE <u>James P. Allen</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Margaret Carson, Des Moines, Iowa</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>Hypertensive Cardiovascular Renal Disease</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Gen. Arteriosclerosis</u> DUE TO (c) <u>Lucid Arteritis with Aortic Insufficiency</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>UNKNOWN</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs</u> <u>1.5 yrs?</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		442XB	
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) (Minute) _____		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>24 Feb 1956</u> to <u>March 4</u> , 1956, that I last saw the deceased alive on <u>4 MAR</u> , 1956, and that death occurred at <u>10:19 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Em M. Clarke</u> (Degree or title) <u>M.D.</u>		23b. ADDRESS <u>Marshall Mo.</u>		23c. DATE SIGNED <u>6 MAR '56</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>3/8/56</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Mariah Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Slater, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>3-7-56</u>		REGISTRAR'S SIGNATURE <u>Cecil V. Reed, Deputy</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>George H. Green</u>		ADDRESS <u>Marshall Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10-480972
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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 George H. Green
Licensed Embalmer No. 42
P. O. Address Barab

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.