

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9378**

FILED APR 10 1957

BIRTH NO. _____ REG. DIST. NO. 209 PRIMARY REG. DIST. NO. 3043 Registrar's No. 127

1. PLACE OF DEATH a. COUNTY <u>Marion</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Marion</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Hannibal</u>		c. CITY OR TOWN <u>Hannibal</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>3 yrs</u>		e. STREET ADDRESS (If rural, give location) <u>1300 A Market St</u> <u>0644</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1300 Amarket St</u>		1300 A Market St <u>0</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>David</u> b. (Middle) <u>Richard</u> c. (Last) <u>Allen</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>4 - 3 - 1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan 10, 1880</u>	9. AGE (In years last birthday) <u>77</u>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor (Ret)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Renick, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>

13a. FATHER'S NAME <u>Thomas Allen</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Wilson</u>		14. NAME OF HUSBAND OR WIFE <u>Ida 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>NO</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Russell Allen (son)</u> <u>Hannibal, Mo.</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Cardiac Failure</u>		DUPLICATE OF (a) <u>Acute Cardiac Failure</u>		<u>5 min</u>	
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES		—	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <u>Arteriosclerosis and senile changes</u>		—	
		DUE TO (c)		—	
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death. <u>Parkinson's Disease</u>		<u>5 yrs</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>	
				<u>4500</u>	

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 <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 Aug 5, 1950, to April 3, 1957, that I last saw the deceased alive on 3/27, 1957, and that death occurred at 12:15 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Sam Buchanan, D.O.</u>		23b. ADDRESS <u>2504 Broadway, Hannibal, Mo.</u>		23c. DATE SIGNED <u>4/5/57</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>4-7-1957</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Vandalia Cemetery</u>	
				24d. LOCATION (City, town, or county) (State) <u>Vandalia, Mo.</u>	

DATE REC'D BY LOCAL REG. <u>4-6-57</u>		REGISTRAR'S SIGNATURE <u>Dr. E. M. Duck...</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Hannibal, Mo.</u>	
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(Licensed Embalmer's Statement on Reverse Side)

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

189
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RECEIVED APR 8 1957
MARION CO. HEALTH DEPT.,
DATE FILED APR 8 1957

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..... *Ralph Clark*

Licensed Embalmer No. *4217*

P. O. Address *Danville, Va*

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.