

pt. Health,  
, & Welfare  
S. Public  
th Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

399901  
STATE FILE NUMBER  
2000  
Registration District No. 125 Primary Registration District No. Registrar's No. 1125

FILED NOV 25 1957

394  
S. 380  
ev. 1-57

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Springfield</b>		c. CITY OR TOWN <b>Springfield</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <b>OZARK POST OPHTHALMIC HOSPITAL</b>		d. STREET ADDRESS <b>1235 N. Ethyl</b>	
Length of stay in hb <b>Life</b>		(If outside, give location) (Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Rickey</b> Middle <b>Lynn</b> Last <b>Allen</b>			4. DATE OF DEATH Month <b>Nov.</b> Day <b>20</b> Year <b>1957</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 19-1957</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <del>100</del> <b>10</b> Months <b>01</b> Days <b>10</b> Hours <b>30</b> Min.
11. BIRTHPLACE (City and state or country) <b>Springfield, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Frank H. Allen</b>		13b. MOTHER'S MAIDEN NAME <b>Helen Eilene Lowe</b>	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Frank H. Allen - Springfield, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Circulatory Failure</b>			INTERVAL BETWEEN ONSET AND DEATH <b>34 1/2 hours</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Congenital Heart Disease</b>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) : <b>7544</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <b>11-19-57</b> to <b>11-20-57</b> and last saw <sup>her</sup> <sub>him</sub> alive on <b>11-20-57</b> Death occurred at <b>11-20-57 10:00 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Arthur Martinick, D.O.</b>		22b. ADDRESS <b>Springfield, Mo</b>	
22c. DATE SIGNED <b>11-20-57</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11-22-57</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Liberty Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Webster County, Mo.</b>	
24. FUNERAL DIRECTOR <b>Springfield, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>11-21-57</b>	
ADDRESS		26. REGISTRAR'S SIGNATURE <b>Conit Williams</b>	

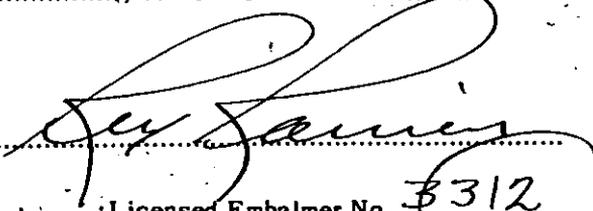
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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  \_\_\_\_\_  
Licensed Embalmer No. 3312  
P. O. Address Springfield, M

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.