

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43155

FILED NOV 18 1957

STATE FILE NUMBER

Registration District No. 323 Primary Registration District No. 6091 Registrar's No. 28

1. PLACE OF DEATH a. COUNTY <u>Saline</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Salt Pond Township</u>				c. CITY OR TOWN <u>Sweet Springs</u>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3 1/2 miles North of Sweet Springs</u>				d. STREET ADDRESS (If outside, give location) <u>3 1/2 miles north of Sweet Spgs.</u>			
3. NAME OF DECEASED (Type or print) First <u>Homer</u> Middle <u>August</u> Last <u>Allen</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>9</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐		8. DATE OF BIRTH <u>Oct 9, 1877</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and state or country) <u>Circleville Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Isaac Allen</u>				13b. MOTHER'S MAIDEN NAME <u>Mina Colven</u>		14. NAME OF HUSBAND OR WIFE <u>Bettie 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>497-42-6007</u>		17. INFORMANT Address <u>Bettie Allen, Sweet Springs, Mo</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cute Myocardial Infarction</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Metastatic Carcinoma</u> DUE TO (c) <u>Carcinoma of Rectum</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>148X</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 wks.</u> <u>2 yrs?</u> <u>?</u>	
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY . Hour . Month, Day, Year a.m. p.m.							
20d. INJURY OCCURRED WHILE AT ☐ NOT WHILE WORK ☐		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 <u>Nov. 8 1957</u> to <u>Nov. 9 1957</u> and last saw him alive on <u>Nov. 9, 1957</u> Death occurred at <u>3:49</u> A m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Physician's title) <u>Paul Roberts, M.D.</u>				22b. ADDRESS <u>Sweet Springs, Mo.</u>		22c. DATE SIGNED <u>11-10-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Nov. 11, 1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Sweet Springs Missouri</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Edgar L. Mosley, Sweet Springs, Mo</u>				25. DATE RECD. BY LOCAL REG. <u>Nov. 11, 1957</u>		26. REGISTRAR'S SIGNATURE <u>Mary Mosley</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

NOV 20 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 *Edgar L. Mosely*

Licensed Embalmer No. *4711*

P. O. Address *Sweet Springs, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.