

FILED JAN 13 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43729

STATE FILE NUMBER

Registration District No. 53

Primary Registration District No. 5188

Registrar's No. 104

104

1. PLACE OF DEATH a. COUNTY <i>Cape Girardeau</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Cape Girardeau</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>4 mi west whitewater</i>		c. CITY OR TOWN <i>near whitewater</i>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Liberty</i>		d. STREET ADDRESS (If outside, give location) <i>4 mi west whitewater</i>	
3. NAME OF DECEASED (Type or print) First <i>VERA</i> Middle <i>GERTRUDE</i> Last <i>ALLMON</i>		4. DATE OF DEATH Month <i>Dec</i> Day <i>7</i> Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 13, 1894</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, except if retired) <i>Retired School teacher</i>		11. BIRTHPLACE (City and state or country) <i>near whitewater Mo</i>	
13. FATHER'S NAME <i>Joseph M. Allmon</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Cargle</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, & unknown) (If yes, give war or dates of service) <i>no</i>		17. INFORMANT <i>Herbert Allmon</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> DUE TO (b) <i>high blood pressure</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <i>30 months</i>	
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.) <i>Home</i>		20f. CITY, TOWN, OR LOCATION <i>Delta Mo</i>	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.		22c. DATE SIGNED <i>Jan 3-58</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		23b. DATE <i>Dec 9, 1957</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Passover</i>		23d. LOCATION (City, town, or county) (State) <i>whitewater Mo</i>	
24. FUNERAL DIRECTOR <i>Wm. Miller</i>		25. DATE DECD BY LOCAL REG. <i>12-19-57</i>	
26. REGISTRAR'S SIGNATURE <i>Elizabeth Summers</i>			

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

44 - 1

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 *Gene C. Canast*

Licensed Embalmer No. *43*

P. O. Address *Jackson,*

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.