

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-038922

STATE FILE NUMBER

FILED NOV 17 1958

Registration District No. 042

Primary Registration District No. 1000

Registrar's No. 1214

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>St. Joseph</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Joseph</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hosp. #2</u>			Length of stay in lb <u>Tyr. 5 mo.</u>	d. STREET ADDRESS (If outside, give location) <u>827 POWELL</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>LULU</u> Middle <u>ALLEN</u> Last <u>ALLEN</u>				4. DATE OF DEATH Month <u>November</u> Day <u>10</u> , Year <u>1958</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 12, 1893</u>		9. AGE (In years last birthday) <u>65</u>	10. UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	11. UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LAUNDRY WORKER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>REA, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>ALBERT ALLEN</u>		13b. MOTHER'S MAIDEN NAME <u>LOUISA BARRISTER</u>		14. NAME OF HUSBAND OR WIFE <u>NONE</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>489-36-0247</u>		17. INFORMANT Address <u>Records, State Hosp. #2 St. Joseph</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>CARCINOMA OF HEAD OF PANCREAS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 Months</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. } DUE TO (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)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 of PART II of item 18.) <u>157X</u>				
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____							
20d. INJURY OCCURRED WHILE AT <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 <u>August 30, 1958</u> to <u>Nov. 10, 1958</u> and last saw her alive on <u>Nov. 10, 1958</u> Death occurred at <u>11:00 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Mohammad Tahir M.D.</u>				22b. ADDRESS <u>State Hospital #2 St. Joseph</u>		22c. DATE SIGNED <u>11-10-58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>Nov. 10, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LOWER NEELY GROVE</u>		23d. LOCATION (City, town, or county) (State) <u>ROSENDALE MISSOURI</u>		
24. FUNERAL DIRECTOR <u>Brit Funeral Home</u>		ADDRESS <u>Savannah Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Nov. 10, 1958</u>		26. REGISTRAR'S SIGNATURE <u>Mr. Clark Goodell</u>	

(Licensed Embalmer's Statement on Reverse Side)

ALL diseases in Part I must be causally related.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
Dr. Mohammad Tahir

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 *James B. Hawkins*

Licensed Embalmer No. *4536*

P. O. Address *Savannah, Ga.*

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.