URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS NOV 3 0 1959

59-041501

STATE FILE NUMBER

AMENDED

Registration District No. _____ Primary Registration District No. _____ Registration No. 210819

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N GRAND, ST LOUIS, MO.
Length of stay in 1b: 37 DAYS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: VET. ADM. HOSPITAL
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI
b. COUNTY: PIKE
c. CITY OR TOWN: CYRENE
Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): RR #2
Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First CLAUDE Middle R. Last ALLEN
4. DATE OF DEATH: Month NOVEMBER Day 22 Year 1959
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 8-19-92
9. AGE (last birthday): 67
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HR: Hours ____ Min. ____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER
10b. KIND OF BUSINESS OR INDUSTRY: - -
11. BIRTHPLACE (City and state or country): TROY, MISSOURI
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: JOHN ALLEN
13b. MOTHER'S MAIDEN NAME: ELIZABETH RUSH
14. NAME OF HUSBAND OR WIFE: ROSA ALLEN
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WW-1
16. SOCIAL SECURITY NO.: 486-14-1664
17. INFORMANT: VA HOSP. RECORDS, ST. LOUIS, MO. Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARCINOMA OF THE STOMACH WITH METASTASES — INTERVAL BETWEEN ONSET AND DEATH: 18 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): 151X
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
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 a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT 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/VA attended the deceased from 10-16-59, to 11-22-59 and last saw him alive on 11-22-59
Death occurred at 9:25 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: John M. Carey (Degree or title) M.D.
22b. ADDRESS: VAH, ST. LOUIS, MO.
22c. DATE SIGNED: 11-22-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 11-25-59
23c. NAME OF CEMETERY OR CREMATORY: Edgewood Cemetery
23d. LOCATION (City, town, or county) (State): Edgewood Mo

24. FUNERAL DIRECTOR: BANKHEAD FUNERAL CHAPEL, MO. ADDRESS: BOWLING GREEN
25. DATE RECD. BY LOCAL REG.: NOV 23 1959
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D. MDC

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by r

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Harold Kirk

Signature of Student Embalmer

Licensed Embalmer No. 4597

P. O. Address Pawling N

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com 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.