

# FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

=60-015959

FILED VS. MAY 4 1960

170

Primary Registration District No. \_\_\_\_\_ Registrar's No. 74

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Laclede</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Laclede</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Eldridge T.S.</b>		Length of stay in 1b <b>31 Yrs.</b>	c. CITY OR TOWN <b>Eldridge</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Eldridge</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Star Rt.</b>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charley Harrison Allen</b>			4. DATE OF DEATH Month Day Year <b>April 18, 1960</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>2/9/80</b>	9. AGE (last birthday) <b>80</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>	11. BIRTHPLACE (City and state or country) <b>Douglas County Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Unknown</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>None.</b>		
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 Address <b>Mr. J. D. Cole, Eldridge, 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>Cerebral Hemorrhage</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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) <b>Old Pulmonary TB - Healed</b>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <b>no</b> <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. Month, Day, Year						
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>May 1946</b> to <b>1946</b> and last saw her alive on <b>1949</b> Death occurred <b>11:30 A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <b>Paul A. Johnson M.D.</b>			22b. ADDRESS <b>Lebanon, Mo</b>		22c. DATE SIGNED <b>April 19, 1960</b>	
23a. BURIAL, CREMATION, REINTERMENT (Specify) <b>Burial</b>	23b. DATE <b>4/20/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Zion Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Laclede County Missouri</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Dr. Palmer Lebowitz, Mo</b>		25. DATE RECD. BY LOCAL REG. <b>4-27-1960</b>	26. REGISTRAR'S SIGNATURE <b>Mella L. Day</b>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Stanley R. Pal

Licensed Embalmer No. 4810

P. O. Address Lehonor,

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.