URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS APR 19 1960

-60-018100

STATE FILE NUMBER

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 80

1. PLACE OF DEATH
a. COUNTY Vernon
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Washington Township.
Length of stay in 1b 11 Months
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hosp. #3
Inside Limits Yes ☐ No ☑

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Ozark
c. CITY OR TOWN Gainesville.
Inside Limits Yes ☐ No ☑
d. STREET ADDRESS (If outside, give location) None
Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Alonzo Middle Allen. Last
4. DATE OF DEATH Month March Day 29 Year 1960
5. SEX M
6. COLOR OR RACE W
7. Married ☑ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH June 6, 1891
9. AGE (last birthday) 68 YTS - 9 MO
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 Farming
11. BIRTHPLACE (City and state or country) Missouri
12. CITIZEN OF WHAT COUNTRY U.S
13a. FATHER'S NAME John Allen
13b. MOTHER'S MAIDEN NAME Lilly Lankford
14. NAME OF ~~HUSBAND~~ OR WIFE Ollie Allen
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (~~Yes~~, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 493-16-7566X
17. INFORMANT Records State Hosp #3 Address Nevada, Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Lobar pneumonia	several days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Thrombo-phlebitis	several month
DUE TO (c)	Cardio-Vascular disease	several years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Mental Deficiency - Idiopathic - Mild

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 attended the deceased from April 27, 1959 to March 29, 1960 and last saw ~~her~~ him alive on March 29, 1960
Death occurred at 5:30 p m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Leslie W Wright (Degree or title) MD
22b. ADDRESS State Hosp #3 Nevada, Mo
22c. DATE SIGNED 3/29/60

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 3/30/60
23c. NAME OF CEMETERY OR CREMATORY Local
23d. LOCATION (City, town, or county) (State) Gainesville, Missouri.

24. FUNERAL DIRECTOR Clinkenbeard, ADDRESS Gainsville, Mo.
25. DATE RECD. BY LOCAL REG. 4-11-1960
26. REGISTRAR'S SIGNATURE Anna E Jerry

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed _____

Signature of Student Embalmer

Licensed Embalmer No. 4853

P. O. Address _____

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