

**FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-035573**

**FILED VS** **OCT 17 1960 239**

STATE FILE NUMBER

Registration District No. 2825 Primary Registration District No. 22 Registrar's No. 22

ENDED

<b>1. PLACE OF DEATH</b> a. COUNTY <b>New Madrid</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>New Madrid</b>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Baderville</b>		Length of stay in 1b <b>2 yrs.</b>		c. CITY OR TOWN <b>Marston, Missouri</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Home</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
<b>3. NAME OF DECEASED</b> (Type or print) First <b>EZRA</b> Middle <b>ETHAN</b> Last <b>ALLEN</b>				<b>4. DATE OF DEATH</b> Month <b>Sept.</b> Day <b>8</b> Year <b>1960</b>									
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>1/20/1890</b>		<b>9. AGE (last birthday)</b> <b>70</b>		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HR</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Merchant</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> -----		<b>11. BIRTHPLACE</b> (City and state or country) <b>Goleonda, Ill.</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>					
<b>13a. FATHER'S NAME</b> <b>William Allen</b>				<b>13b. MOTHER'S MAIDEN NAME</b> <b>Mary Shelby</b>				<b>14. NAME OF HUSBAND OR WIFE</b> <b>Lena Allen</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				<b>16. SOCIAL SECURITY NO.</b> <b>489-40-1774</b>		<b>17. INFORMANT</b> Address <b>Lena Allen Baderville, Mo.</b>							
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO (b) <b>Coronary sclerosis</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal illness condition given in PART I (a) <b>Diabetes Mellitus</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			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)									
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m.		Month, Day, Year _____											
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)			<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b>		<b>STATE</b>				
<b>21. I attended the deceased from</b> <u>1956</u> <b>to</b> <u>Sept 1960</u> <b>and last saw him live on</b> <u>7 Sept '60</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.													
<b>22a. SIGNATURE</b> (Degree or title) <i>H. C. Gaunter Jr. M.D.</i>						<b>22b. ADDRESS</b> <b>Portageville, Mo</b>				<b>22c. DATE SIGNED</b> <b>26 Sept '60</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE</b> <b>9/11/1960</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Parma Cemetery</b>				<b>23d. LOCATION</b> (City, town, or county) <b>Parma, Missouri</b>		(State)			
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>RICHARDS New Madrid, Mo.</b>						<b>25. DATE RECD. BY LOCAL REG.</b> <b>Oct 4, 1960</b>		<b>26. REGISTRAR'S SIGNATURE</b> <i>Dr. Geo. W. ...</i>					

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



Licensed Embalmer No. 5102

P. O. Address New Mexico

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.