

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-011898

STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 134

DO NOT WRITE ON THIS STUB

AMENDED

<p>FILED APR 16 1962</p> <p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Marion</u></p> <p>b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hannibal</u> Length of stay in 1b _____</p> <p>c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Levering Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>		<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u></p> <p>c. CITY OR TOWN <u>Hannibal</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <u>2515 Hope Street</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>				
<p>3. NAME OF DECEASED (Type or print)</p> <p>First <u>John</u> Middle <u>Richard</u> Last <u>Allen</u></p>		<p>4. DATE OF DEATH</p> <p>Month <u>April</u> Day <u>4</u> Year <u>1962</u></p>				
<p>5. SEX <u>Male</u></p>	<p>6. COLOR OR RACE <u>Negro</u></p>	<p>7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>Dec. 18, 1873</u></p>	<p>9. AGE (last birthday) <u>88</u></p>	<p>IF UNDER 1 YEAR Months _____ Days _____</p>	<p>IF UNDER 24 HR Hours _____ Min. _____</p>
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u></p>		<p>11. BIRTHPLACE (City and state or country) <u>Hester, Missouri</u></p>		<p>12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u></p>
<p>13a. FATHER'S NAME <u>John Allen</u></p>			<p>13b. MOTHER'S MAIDEN NAME _____</p>		<p>14. NAME OF HUSBAND OR WIFE <u>Flossie Allen</u></p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u></p>		<p>16. SOCIAL SECURITY NO. _____</p>		<p>17. INFORMANT Address <u>2515 Hope St.</u> <u>Mrs. Flossie Allen Hannibal, Missouri</u></p>		
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:</p>						<p>INTERVAL BETWEEN ONSET AND DEATH</p>
<p>IMMEDIATE CAUSE (a) <u>Terminal pneumonia</u></p>					<p><u>7 days</u></p>	
<p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral hemorrhage</u></p>					<p><u>10 days</u></p>	
<p>DUE TO (c) _____</p>					<p>_____</p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)</p>				<p>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</p>		
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	<p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p>	<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>				
<p>20c. TIME OF INJURY Hour _____ Month, Day, Year _____</p>						
<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/></p>		<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____</p>		<p>20f. CITY, TOWN, OR LOCATION COUNTY STATE _____</p>		
<p>21. I attended the deceased from <u>2/4/62</u> to <u>4/4/62</u> and last saw her <u>him</u> alive on <u>4/4/62</u></p> <p>Death occurred at <u>11:35 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.</p>						
<p>22a. SIGNATURE (Degree or title) <u>J. H. Watterchines M.D.</u></p>			<p>22b. ADDRESS <u>1209 Broadway, Hannibal, Mo.</u></p>		<p>22c. DATE SIGNED <u>4/6/62</u></p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>		<p>23b. DATE <u>Apr. 7, 1962</u></p>	<p>23c. NAME OF CEMETERY OR CREMATORY <u>Robinson Cemetery</u></p>		<p>23d. LOCATION (City, town, or county) (State) <u>Hannibal, Missouri</u></p>	
<p>24. GENERAL DIRECTOR ADDRESS <u>Geo E Roberts Hannibal, Mo.</u></p>		<p>25. DATE RECD. BY LOCAL REG. <u>April 9, 1962</u></p>		<p>26. REGISTRAR'S SIGNATURE <u>Dr. E. M. Luedtke by Gillian M. Roman</u></p>		

VS 300 Rev. 4/59

1 0648

2 0648

3 2

4 2

5 1

6 _____

7 0

8 0

9331X

10 _____

11 _____

12 1-0

13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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 George E. Roberts
George E. Roberts
Licensed Embalmer No. 2113
P. O. Address Hannibal, Missouri

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.

Robert's record
4/9/62