

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-018754

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 133 Primary Registration District No. 3022 Registrar's No. 75 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. <b>FILED JUN - 5 1962</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>HARRISON</u>		a. STATE <u>MO</u>	b. COUNTY <u>DAVIESS</u>
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>BETHANY</u>		Length of stay in lb <u>40 days</u>	c. CITY OR TOWN <u>ALTAMONT</u>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>NOLL HOSPT</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <u>ALTAMONT</u>
3. NAME OF DECEASED (Type or print)		First <u>ABRAHAM</u> Middle <u>LINCOLN</u> Last <u>ALLEN</u>	4. DATE OF DEATH <u>MAY 29-1962</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1-17-1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <u>75</u>
13a. FATHER'S NAME <u>CHARLES B. ALLEN</u>		13b. MOTHER'S MAIDEN NAME <u>ANNA FULK</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>12</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>[REDACTED]</u>	IF UNDER 24 HR Hours <u>12</u> Min. <u></u>
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:		11. BIRTHPLACE (City and state or country) <u>UNION STAR MO</u>	
IMMEDIATE CAUSE (a) <u>Thrombo-embolism</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		14. NAME OF <del>HUSBAND</del> OR WIFE <u>FRANCIS ALLEN</u>	
DUE TO (b) <u>Coronary Atherosclerosis</u>		17. INFORMANT <u>FRANCIS ALLEN ALTAMONT MO</u>	
DUE TO (c)		Address <u>ALTAMONT MO</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pulmonary Emphysema</u>		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 <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <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 <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></u>	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 <u>August 1961</u> to <u>May 29, 1962</u> and last saw her/him alive on <u>May 25, 1962</u>		Death occurred at <u>12:30</u> a. m. on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>J. Larry Lowell M.D.</u> (Degree or title)		22b. ADDRESS <u>Pattonsburg, Mo.</u>	22c. DATE SIGNED <u>5-30-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>5-31-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT AYERS</u>	23d. LOCATION (City, town, or county) (State) <u>ALTAMONT MO</u>
24. FUNERAL DIRECTOR <u>Virgil H. Stump</u> ADDRESS <u>Winstan Mo</u>	25. DATE RECD. BY LOCAL REG. <u>5-30-1962</u>	26. REGISTRAR'S SIGNATURE <u>Gella Mayes</u>	

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

*Virgil W. Stramp*

Licensed Embalmer No. 4074

P. O. Address Winston

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.