

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-041758

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

District No. 43 Primary Registration District No. 3007 Registrar's No. 1117

FILED NOV 26 1962

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. PLACE OF DEATH a. COUNTY BUTLER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY BUTLER	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN POPLAR BLUFF		Length of stay in lb 338 DAYS	c. CITY OR TOWN POPLAR BLUFF Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS 1124 COMMERCE (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) JAMES TURNER ALLEN		4. DATE OF DEATH Month NOV Day 17 Year 1962	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4-2-95
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING	9. AGE (last birthday) 67 IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours _____ Min. _____
11. BIRTHPLACE (City and state or country) RECTOR ARK		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME ROBERT ALLEN		13b. MOTHER'S MAIDEN NAME TILDA CUMMINS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, state branch or dates of service) YES		16. SOCIAL SECURITY NO. WWT	
17. INFORMANT VA HOSPITAL POPLAR BLUFF, MO.		Address	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MULTIPLE MYELOMA Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 1 YEAR
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			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 _____ 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. <input checked="" type="checkbox"/> attended the deceased from 9-16-61 to 11-17-62 Death occurred at 6:35AM on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Robert S. Cohen M.D. Chief Med. Scv.		22b. ADDRESS VA. HOSPITAL POPLAR BLUFF, MO.	22c. DATE SIGNED 11-20-62
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11-19-62	23c. NAME OF CEMETERY OR CREMATORY Williams Cemetery	23d. LOCATION (City, town, or county) (State) Corning, Ark
24. FUNERAL DIRECTOR Irby Funeral Home Rector, Ark.		25. DATE RECD. BY LOCAL REG. 11/23/1962	26. REGISTRAR'S SIGNATURE <i>Thelma Graham</i>

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

NOV 30 1962

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 W. H. Selby

Licensed Embalmer No. 264

P. O. Address _____

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.