DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 37163

Registration District No. FILED NOV 28 1945 Primary Registration District No. 2000 Registrar's No. 897

1. PLACE OF DEATH:
(a) County GREENE
(b) City or town SPRINGFIELD
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1023 TEXAS
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County GREENE
(c) City or town SPRINGFIELD
(If outside city or town limits, write "RURAL")
(d) Street No. 1023 TEXAS
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME JAMES ALLEN
3. (b) If veteran, name war UNK.
3. (c) Social Security No. UNK.

4. Sex MALE
5. Color or race Negro
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife MARY ALLEN
6. (c) Age of husband or wife if alive UNK. years
7. Birth date of deceased Oct. (Month) 6 (Day) 1919 (Year)

8. AGE: Years 26 Months 0 Days 25 If less than one day hr. min.

9. Birthplace ASH GROVE (City, town, or county) MO. (State or foreign country)
10. Usual occupation AUTO MECHANIC
11. Industry or business

MOTHER FATHER
12. Name GEORGE ALLEN
13. Birthplace LACENE (City, town, or county) KANS. (State or foreign country)
14. Maiden name FANNIE HERRON
15. Birthplace UNK. (City, town, or county) KANS. (State or foreign country)

16. (a) Informant WILLIAM ALLEN
(b) Address 1023 TEXAS, SPFD., MO.
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11-5-45 (Month) (Day) (Year)
(c) Place: burial or cremation ASH GROVE CEM.
18. (a) Signature of funeral director H. V. Smith
(b) Address 702 N. JEFFERSON, SPFD., MO.
19. (a) 11-5-45 (Date received local registrar) (b) O. W. S. Hanley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 1 year 1945 hour 4 minute 10 P.M.
21. I hereby certify that I attended the deceased from hr. Physician in attendance, 19...; that I last saw h... alive on ..., 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Homicide by Firearms.	
Due to: Shot in Chest	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy: 166	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Homicide
(b) Date of occurrence Nov. 1, 1945
(c) Where did injury occur? Springfield, Greene Mo. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? In the home (Specify type of place)
While at work? No. (e) Means of injury Shot gun
23. Signature C. Stone Coron (M. D. or other)
Address Springfield, Mo. Date signed 11-3-45

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

7. S. No. 2
0M—5-42
ev. 5-17-39
I X32873

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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed..... Herbert V. Smith

Licensed Embalmer No..... 4286

P. O. Address..... Springfield

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 this body is not embalmed, fact should be so stated above.