

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **40783**
Registrar's No. **1119**

BIRTH NO. _____		REG. DIST. NO. 128		PRIMARY REG. DIST. NO. 2000		State File No. 40783		Registrar's No. 1119	
1. PLACE OF DEATH a. COUNTY Greene				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY Greene					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield				c. LENGTH OF STAY (in this place) 50 yrs.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield			
d. FULL NAME OF HOSPITAL OR INSTITUTION 1109 Texas				d. STREET ADDRESS (If rural, give location) 1109 Texas					
3. NAME OF DECEASED (Type or Print) a. (First) GEORGE b. (Middle) W c. (Last) ALLEN				4. DATE OF DEATH (Month) (Day) (Year) 12-16-49					
5. SEX M		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH MAY 24 - 1874		9. AGE (In years last birthday) 75	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Laine Kans.		12. CITIZEN OF WHAT COUNTRY? U.S.			
13a. FATHER'S NAME John Allen				13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Deceased			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Wm Allen ADDRESS 1414 W. Webster					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocardial Insufficiency ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. INTERVAL BETWEEN ONSET AND DEATH 4222					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from Nov. 1948 , to Dec. 16, 1949 , that I last saw the deceased alive on Dec 16, 1949 , and that death occurred at 8:54 a.m. , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) Lyman D. Brown M.D.				23b. ADDRESS 311 1/2 Boonville			23c. DATE SIGNED 12/16/49		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 12-19-49		24c. NAME OF CEMETERY OR CREMATORY Sh Grove Cem		24d. LOCATION (City, town, or county) (State) Sh Grove Mo			
DATE REC'D BY LOCAL REG. 12-22-49		REGISTRAR'S SIGNATURE W.E. Handley		FUNERAL DIRECTOR'S SIGNATURE W.E. Handley		ADDRESS 602 N Jefferson			

(Licensed Embalmer's Statement on Reverse Side)

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

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.

Signed _____

Herbert V. Smith

Signed _____

Student Embalmer

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.