

No. 300
10.48

JUL 28 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 24264

BIRTH NO. _____ REG. DIST. NO. 137 PRIMARY REG. DIST. NO. 3023 Registrar's No. 48

1. PLACE OF DEATH a. COUNTY Henry		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Blair	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Clinton		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Monegaw Springs (Rural)	
c. LENGTH OF STAY (in this place) One week		d. STREET ADDRESS (If rural, give location) 0930 (East Osage)	
d. FULL NAME OF HOSPITAL OR INSTITUTION Moore's Nursing Home			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) Alton	b. (Middle) Homer	c. (Last) Allen	(Month) July	(Day) 19	(Year) 1952
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH May 23, 1868	9. AGE (In years last birthday) 84	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Missouri	
				12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME James M. Allen		13b. MOTHER'S MAIDEN NAME Elizabeth Cleveland		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Ira Allen, Osceola Missouri	
				ADDRESS	

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		INTERVAL BETWEEN ONSET AND DEATH Heart 1 week Unkown
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive heart failure		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arterio-sclerotic degenerative disease		
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION 4331	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Us		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 July 15, 1952, to July 19, 1952, that I last saw the deceased alive on July 18, 1952, and that death occurred at 6:40 m., from the causes and on the date stated above.

23a. SIGNATURE S.B. Hughes, M.D.		23b. ADDRESS Clinton, Mo		23c. DATE SIGNED 7/21/52	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 7/21/1952		24c. NAME OF CEMETERY OR CREMATORY Benton Green	
				24d. LOCATION (City, town, or county) (State) Roscoe Missouri.	

DATE REC'D BY LOCAL REG. July-21-52		REGISTRAR'S SIGNATURE Florence Adair		25. FUNERAL DIRECTOR'S SIGNATURE F.B. ...	
				ADDRESS Osceola Mo	

(Licensed Embalmer's Statement on Reverse Side)

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

422
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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
Student Embalmer

Signed J.B. Smith

Licensed Embalmer No. 3038

P. O. Address Quebec 710

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.