

FILED NOV 26 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-041172

STATE FILE NUMBER

Registration District No. 311 Primary Registration District No. 4456 Registrar's No. 40

1. PLACE OF DEATH a. COUNTY <u>St. Clair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Henry</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Appleton City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Urich</u> 04200 Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>West Dover St. Approx 4 mas.</u>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Franklin Allen</u>			4. DATE OF DEATH Month Day Year <u>Nov. 22-1958</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 checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June-25-1886</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. <u>72</u> Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (City and state or country) <u>Hartwell, Mo.</u>
13a. FATHER'S NAME <u>Henry Allen</u>		13b. MOTHER'S MAIDEN NAME <u>Catherine Dixon</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</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>None</u>	14. NAME OF HUSBAND OR WIFE <u>ANN S. PARKER ALLEN</u>
17. INFORMANT <u>Richard Allen, Deepwater, Mo.</u>			Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GASTRIC HEMORRHAGE</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>C.A. STOMACH</u>			<u>Unknown</u>
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>
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.) <u>151X</u>	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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>15 Aug 1958</u> to <u>Nov 22 1958</u> and last saw her alive on <u>Nov 22 1958</u> Death occurred at <u>6:12</u> p.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Robert H. Braunschweig MD</u>		22b. ADDRESS <u>Appleton City, Mo.</u>	22c. DATE SIGNED <u>Nov 24 1958</u>
23a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>		23b. DATE <u>Nov-26-1958</u>	23c. NAME OF CEMETERY OR CREMATOR <u>White Oak Cemetery</u>
23d. LOCATION (City, town, or county) <u>8 miles N.W. Montrose, Mo.</u>		(State)	
24. FUNERAL DIRECTOR <u>Melvin L. Janssens</u>		25. DATE RECD. BY LOCAL REG. <u>Nov. 25, 1958</u>	26. REGISTRAR'S SIGNATURE <u>Clas Abney</u>
(Licensed Embalmer's Statement on Reverse Side)			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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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 .....  
Signature of Student Embalmer

Signed

*Melvin L. Janssens*

Licensed Embalmer No. 4529

P. O. Address Appleton, Wis.

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.