

MISSOURI DIVISION OF HEALTH—STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE



DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 70040101 STATE FILE NUMBER

VS 300 Rev. 4/59

1 0425

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

<p>1. PLACE OF DEATH (If outside corporate limits, give TOWNSHIP only) Length of stay in 1b</p> <p>a. STATE <u>MO</u> b. COUNTY <u>Henry</u></p> <p>c. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits <u>Clinton</u> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) Reside on Farm <u>General Hosp.</u> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>		<p>2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)</p> <p>a. STATE <u>MO</u> b. COUNTY <u>Henry</u></p> <p>c. CITY OR TOWN <u>Urich</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/></p>	
<p>3. NAME OF DECEASED (Type or print) First Middle Last <u>Henry Wilson Allee</u></p>		<p>4. DATE OF DEATH Month Day Year <u>Nov 2 1964</u></p>	
<p>5. SEX <u>male</u></p>	<p>6. COLOR OR RACE <u>white</u></p>	<p>7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>Nov 1882</u></p>
<p>9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR <u>82</u> Months Days Hours Min.</p>		<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p>	
<p>10b. KIND OF BUSINESS OR INDUSTRY <u>Ministry</u></p>		<p>11. BIRTHPLACE (City and state or country) <u>California, MO</u></p>	
<p>12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u></p>		<p>13a. FATHER'S NAME <u>Thomas Edward Allee</u></p>	
<p>13b. MOTHER'S MAIDEN NAME <u>Sally Ann Birdsong</u></p>		<p>14. NAME OF HUSBAND OR WIFE <u>Blanche H. Allee</u></p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u></p>		<p>16. SOCIAL SECURITY NO. <u>none</u></p>	
<p>17. INFORMANT Address <u>Blanche H. Allee, Urich, MO</u></p>		<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:</p>	
<p>IMMEDIATE CAUSE (a) <u>Pneumonia Lobar</u></p>		<p>INTERVAL BETWEEN ONSET AND DEATH <u>4 da</u></p>	
<p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.</p>		<p>DUE TO (b) _____</p>	
<p>DUE TO (c) _____</p>		<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)</p>	
<p>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</p>		<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>	
<p>20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year</p>		<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>	
<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>20f. CITY, TOWN, OR LOCATION COUNTY STATE</p>	
<p>21. I attended the deceased from <u>10-31</u> to <u>11-2-64</u>, to _____ and last saw her/him alive on <u>11-2-64</u>. Death occurred at <u>12 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.</p>			
<p>22a. SIGNATURE (Degree or title) <u>H. Walker M.D.</u></p>		<p>22b. ADDRESS <u>1261 N. 3rd Clinton MO</u></p>	
<p>22c. DATE SIGNED <u>11-3-64</u></p>		<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u></p>	
<p>23b. DATE <u>Nov 4/64</u></p>		<p>23c. NAME OF CEMETERY OR CREMATORY <u>Clarkburg cem Clarkburg MO</u></p>	
<p>23d. LOCATION (City, town, or county) (State) _____</p>		<p>24. FUNERAL DIRECTOR ADDRESS <u>Snow 7 Home Urich MO</u></p>	
<p>25. DATE RECD. BY LOCAL REG. <u>11-3-1964</u></p>		<p>26. REGISTRAR'S SIGNATURE <u>Waldred Bigum</u></p>	

USE BLACK INK OR TYPEWRITER RIBBON

STATE OF MISSOURI
DEPARTMENT OF HEALTH
DIVISION OF ANATOMY
AND EMBALMING

NOV 16 1964

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 Eugene R. Conzelmann

Licensed Embalmer No. 4680

P. O. Address Clinton, Mo.

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.