

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

65-047688

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 319

FILED DEC 28 1965

VS 300  
Rev. 4/59

1 0425  
2 0430  
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9 454 X  
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Henry</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Hickory</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Clinton</b>		Length of stay in 1b <b>2 weeks</b>	c. CITY OR TOWN <b>Weaubleau</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) <b>Wetzel Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	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 <b>RANNIE</b> Middle <b>LOUIS</b> Last <b>ALLEN</b>			4. DATE OF DEATH Month <b>December</b> Day <b>18</b> Year <b>1965</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7/23/95</b>
9. AGE (last birthday) <b>70</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	11. BIRTHPLACE (City and state or country) <b>Not known</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>Archie J. Allen</b>	
13b. MOTHER'S MAIDEN NAME <b>// Sarah Shelton</b>		14. NAME OF HUSBAND OR WIFE <b>Zula Allen, Deceased</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Not known</b>		16. SOCIAL SECURITY NO. <b>491-42-6864</b>	17. INFORMANT <b>Ross Allen, Springfield, Missouri</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Medullary Paralysis</b> DUE TO (b) <b>Cerebral Embolus</b> DUE TO (c) <b>Thrombosis of Femoral Artery</b>			INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>24 hrs.</b> <b>7 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Generalized Arteriosclerosis</b>			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
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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.)	
20c. TIME OF INJURY Hour a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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 <b>1964</b> to <b>12-18-65</b> and last saw <b>him</b> alive on <b>12-18-65</b> Death occurred at <b>1:55 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>C. L. Glosop, D.O.</b>		22b. ADDRESS <b>Clinton, Mo.</b>	22c. DATE SIGNED <b>12/20/65</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Dec 19, 65</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Butcher Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Weaubleau, Missouri</b>
24. FUNERAL DIRECTOR <b>Hathaway</b>		ADDRESS <b>Wheatland, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>12-21-65</b>
26. REGISTRAR'S SIGNATURE <b>Mildred Bigums</b>			

**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 B. Consalter

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.

Permit Obtained 12-21-68 MB