

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

19244  
Do not use this space.

*D. S. Martin*  
JUN 21 1939

1. PLACE OF DEATH  
(a) County *Miss.* Registration District No. *567*  
(b) Township \_\_\_\_\_ Primary Registration District No. *4334*  
(c) City *East Prairie* (d) Street No. \_\_\_\_\_ Registered No. *35*  
(If death occurred in Hospital or Institution, write its name instead of street and number) St.  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *CLIFFORD DEWAYNE ALLEN*

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male*  
4. COLOR OR RACE *White*  
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) \_\_\_\_\_

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *May 19 - 1939*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
*10*

OCCUPATION  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *infant*  
9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *East Prairie, Mo.*

FATHER  
13. NAME *Tall Allen*  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Callaway, Ky.*

MOTHER  
15. MAIDEN NAME *Thelma James*  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Seatt. W. Mo.*

17. INFORMANT (ADDRESS) *Tall Allen, East Prairie, Mo.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Ignored* DATE *5729* 19*39*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *James Shelby, East Prairie, Mo.*

20. FILED *June 5, 1939* *Miss D. M. [unclear]*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *May 29, 1939*

22. I HEREBY CERTIFY, That I attended deceased from *May 19, 1939* to *May 29, 1939*  
I last saw him alive on *May 28, 1939* Death is said to have occurred on the date stated above at *11:00 p.m.*  
The principal cause of death and related causes of importance were as follows:  
*Central Aneurysm due to Injury during birth*  
Date of onset \_\_\_\_\_

Other contributory causes of importance: \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_  
(Signed) *D. Martin*, M. D.  
(Address) *Elmwood, Mo.*

**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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, above space should be left blank.**