

Registration District No. 411

Primary Registration District No. 2002

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Jasper  
(b) City or town Joplin  
(c) Name of hospital or institution St. John's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 months (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Cherokee  
(c) City or town Galena  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

8. (a) PRINT FULL NAME MICHAEL P. ALLEN

8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced MARRIED  
6. (b) Name of husband or wife Minnie 6. (c) Age of husband or wife if alive 42 years  
7. Birth date of deceased 9 (Month) 6 (Day) 1890 (Year)

8. AGE: Years 49 Months 2 Days 2 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Galena Kansas  
(City, town, or county) (State or foreign country)

10. Usual occupation Restaurant owner

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name W. W. Allen  
13. Birthplace Mo.  
14. Maiden name Martha M. Allen  
15. Birthplace Mo.

16. (a) Informant's own signature Mike Allen Jr.

(b) Address Galena, Kansas

17. (a) Removal (b) Date thereof 11-8-39  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Galena, Kas.

18. (a) Signature of funeral director W. J. Reynolds

(b) Address Joplin, Mo.

19. (a) 11-9-39 (b) W. J. Reynolds  
(Date received local registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 8<sup>th</sup> year 1939 hour 11:20 minute \_\_\_\_\_ A. M.

21. I hereby certify that I attended the deceased from Jan 1939 to Nov 1939, that I last saw him alive on Nov 8 and that death occurred on the date and hour stated above.

Immediate cause of death Heart Attack

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations none

Of autopsy none

PHYSICIAN  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) none

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? none

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature H. M. Winchester (M. D. or other) \_\_\_\_\_

Address Joplin, Mo. Date signed 11/8/39

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.

RECEIVED

District Health Officer No. 6,

Subject File Number: 1289-2479

Date Filed DEC 7 1939

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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.....

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

Signed F. M. Jones

Licensed Embalmer No. 2319

P. O. Address Japhin Me

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.