

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

21566

State File No. _____

Registration District No. 213

Primary Registration District No. 2014

Registrar's No. 152

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.

1. PLACE OF DEATH:

(a) County Cole

(b) City or town Jefferson City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Marys
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Four days
(Specify whether years, months or days)

In this community all of life

3. (a) PRINT FULL NAME John William Allen 457

3. (b) If veteran, name war _____

3. (c) Social Security No. none

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years (Day) (Year)

7. Birth date of deceased 11 20 1874
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

65	7	1	hr. _____ min.
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9. Birthplace Callaway Co. Missouri ()
(City, town, or county) (State or foreign country)

10. Usual occupation River worker

11. Industry or business Govern works

12. Name James Allen

13. Birthplace Virginia
(City, town, or county) (State or foreign country)

14. Maiden name Sallie Newton

15. Birthplace Virginia
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Adam Boyce

(b) Address Tebbetts, Missouri

17. (a) Burial (b) Date thereof 6 23 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Riverview

18. (a) Signature of funeral director Raymond Holt

(b) Address New Bloomfield, Missouri

19. (a) 6/22/40 (b) D. A. Boyce
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Callaway

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. Near Tebbetts, Missouri
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 21
year 1940 hour 10 minute 15 P.M.

21. I hereby certify that I attended the deceased from June 18, 1940 to June 21, 1940
that I last saw him live on June 21, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Accompensated Heart Duration 1 year

Due to arteriosclerosis and Mitral Regurgitation

Due to _____

Other conditions Nephritis

(Include pregnancy within 3 months of death)

Major findings: Chronic

Of operations _____

Of autopsy 121

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) _____

(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? _____

While at work? _____ (Specify type of place) (d) Means of injury _____

23. Signature J. G. Bruce (M. D. or other) M.D.

Address Jefferson City, Mo Date signed June 21/40

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 *Ray A. Holt*

Licensed Embalmer No. *2605*

P. O. Address *Chen Bloomfield, Va*

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.