

FILED OCT 21 1941

Registration District No. **1111**

Primary Registration District No. **5160**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Callaway**
 (b) City or town **Fossil Township**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Stephens, Mo. Route 1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)
 In this community **Entire Life**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Callaway**
 (c) City or town **Fossil**
(If outside city or town limits, write "RURAL")
 (d) Street No. **Chickadee Township**
(If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME

ELLA NORA ALLEN

3. (b) If veteran, name war **None**

3. (c) Social Security No. **None**

5. Color or race **Female white**
 6. (a) Single, widowed, married, divorced **Single**
 6. (b) Name of husband or wife **None**
 6. (c) Age of husband or wife if alive **None** years
 7. Birth date of deceased **Aug 7 1854**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	87	0	20	hr. _____ min. _____

9. Birthplace **Fossil County Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation **None**

11. Industry or business

12. Name **John P. Allen**
 13. Birthplace **Virginia**
(City, town, or county) (State or foreign country)
 14. Maiden name **Ellen West**
 15. Birthplace **Virginia**
(City, town, or county) (State or foreign country)

16. (a) Informant **Charles D. Brown**

(b) Address **Stephens, Mo**

17. (a) **Funeral** (b) Date thereof **Aug 29 41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Forest Cemetery**

18. (a) Signature of funeral director **Charles D. Brown**

(b) Address **Columbia, Mo**

19. (a) **Sept. 3, 1941** (b) **B.H. Stephens**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **29**
 year **1941** hour **2:00** minute **30** A.M.

21. I hereby certify that I attended the deceased from **7-20-**
1941 to **8-27-** **1941**
 that I last saw her alive on **8-23-** **1941**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Intestinal Ob-
 struction Probably
 malignant** **1 Mo.**
 Due to **Probably Carcinoma**

Due to **Intestinal**

Other conditions **462**
(include pregnancy within 3 months of death)

Major findings: **none**
 Of operations **none**
 Of autopsy **none**

Duration
 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) **No**
 (b) Date of occurrence **No**
 (c) Where did injury occur? **No**
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
No
(Specify type of place) (e) Means of injury

23. Signature **W. D. Deyard** (M. D. or other) **M.D.**
 Address **Columbia, Mo.** Date signed **8-27-41**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

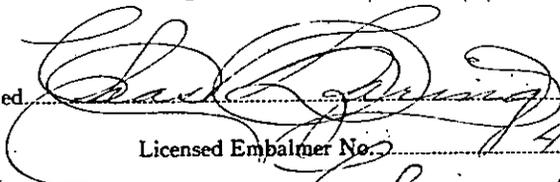
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STATEMENT BY LICENSED EMBALMER

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 
Licensed Embalmer No. 413
P. O. Address Columbia

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.