S. No. 2
M—5-42
y. 5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 7 1942

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 36083

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4316

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town K C Mo (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Home 12416 Olive. (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Home (Specify whether
In this community 42 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson 48
(c) City or town K C Mo (If outside city or town limits, write "RURAL")
(d) Street No. 2416 Olive (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME LEWIS ALLEN
3. (b) If veteran, name war NO
3. (c) Social Security No. NONE
4. Sex MALE
5. Color or race 2 NEGRO
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife AMANDA ALLEN
6. (c) Age of husband or wife if alive 78 years
7. Birth date of deceased SEPT (Month) 15 (Day) 1872. (Year)

8. AGE: Years 70 Months 2 Days 3 If less than one day ..... hr. ..... min.

9. Birthplace Mo (City, town, or county) 0 (State or foreign country)
10. Usual occupation UNEMPLOYED
11. Industry or business
FATHER 12. Name Jim Allen
13. Birthplace Dont Know (City, town, or county) 9 (State or foreign country)
MOTHER 14. Maiden name Dont Know
15. Birthplace Dont Know (City, town, or county) 9 (State or foreign country)
16. (a) Informant Amanda Allen
(b) Address 2416 Olive K C Mo
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 11-20-42 (Month) (Day) (Year)
(c) Place: burial or cremation Kirksville, Mo
18. (a) Signature of funeral director Flynn + Greenstreet
(b) Address 1819 E. 15th
19. (a) 11-20-42 (Date received local registrar) (b) M M Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 18 year 1942 hour 4 00 minute a M.
21. I hereby certify that I attended the deceased from 11/17/ 1942 to 11/18/ 1942 that I last saw h..... alive on ....., 19....; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemorrhage	6 hr
Due to Cardio Vascular hypertension	?
Due to 92A 12H	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations No.
Of autopsy no.

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

22. If death was due to external causes, fill in the following: no.
(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? (Specify type of place)
While at work? (e) Means of injury
23. Signature M M Caldwell MD (M. D. or other)
Address 2131 E. 24th Date signed 11/20/42

(Licensed Embalmer's Statement on Reverse Side)

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. Wm G. Flynn

Licensed Embalmer No. 2211

P. O. Address 1819 E. 15th K C 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 this body is not embalmed, fact should be so stated above.