

FILED APR 13 1944

Registration District No. \_\_\_\_\_

Primary Registration District No. 5162

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

1. PLACE OF DEATH:

(a) County Calloway  
 (b) City or town Stephens  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Rural Route 1  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
 In this community 61 Years  
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Calloway  
 (c) City or town Stephens  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. Rural Route 1  
 (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MAUDE ALLEN

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. sex Female 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

7. Birth date of deceased 1 - 28 - 1883  
 (Month) (Day) (Year)

8. AGE: Years 61 Months 2 Days 5 If less than one day  
 hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Calloway County Missouri  
 (City, town, or county) (State or foreign country)

10. Usual occupation At Home

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

12. Name William C. Allen

13. Birthplace Boone County Missouri  
 (City, town, or county) (State or foreign country)

14. Maiden name Annie Eckley

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

16. (a) Informant A nabelle Allen

(b) Address Route 1, Stephens, Mo.

17. (a) B ural (b) Date thereof 4-5-44  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Chapel Cemetery

18. (a) Signature of funeral director Harlan Funeral Service

(b) Address Columbia, Mo.

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 3  
 year 1944 hour 8:45 minute 1-6 M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_  
 to \_\_\_\_\_  
 that I last saw her alive on 3-29-44  
 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of the Uterus  
Metastatic Duration 2 yrs

Due to First Cancer of Uterus

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

Other conditions \_\_\_\_\_

Major findings: Of operations As above

Of autopsy None

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) (e) Means of injury \_\_\_\_\_

23. Signature W. P. Grant (M. D. or other) \_\_\_\_\_

Address Calloway, Mo. Date signed 4-8-44

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

1147

**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.....

.....  
working under my personal supervision.

Registered Apprentice No. ....

Signed

*Chas. J. ...*  
.....  
Licensed Embalmer No. *4132*  
P. O. Address *Columbia, S.C.*

**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.**

Registration District No. 47 Primary Registration District No. 5162

1. PLACE OF DEATH:  
(a) County Callaway  
(b) City or town Cleverland  
(c) Name of hospital or institution: R.R.I.  
(d) Length of stay: 61 yrs.  
In this community 61 yrs.

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO (b) County Callaway  
(c) City or town Stephens  
(d) Street No. \_\_\_\_\_  
(e) Citizen of foreign country? \_\_\_\_\_

3. (a) PRINT FULL NAME Maude Allen  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_  
4. Sex F 5. Color or race W  
6. (a) Single, widowed, married, divorced S.  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month April year 1944  
21. I hereby certify that I attended the deceased from \_\_\_\_\_  
that I saw him \_\_\_\_\_  
and that death occurred on the date and hour stated above.  
Immediate cause of death Carcinoma  
metastatic

Due to First Cancer of Rectum  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_  
(Specify type of place) \_\_\_\_\_  
(e) Means of injury \_\_\_\_\_  
3. Signature W.P. Dyser (M. D. or other) MO  
Address Columbia, Mo. Date signed \_\_\_\_\_

8. AGE: 61 Years 2 Months 2 Days  
9. Birthplace MO  
10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_  
12. Name \_\_\_\_\_  
13. Birthplace MO  
14. Maiden name Annie Eckler  
15. Birthplace MO  
16. (a) Informant O Arnabelly Allen  
(b) Address Stephens, Mo.  
17. (a) \_\_\_\_\_ (b) Date thereof 4-5-44  
(c) Place: burial or cremation Oak Chapel  
18. (a) Signature of funeral director Parker Funeral  
(b) Address Columbia, Mo.  
19. (a) 4-29-1944 (b) Joie M. \_\_\_\_\_

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

SUPPLEMENTARY

MENTARY

10529