

S. No. 2
00M-5-43
Rev. 5-17-39
I X3667

FILED JUL 16 1946

Registration District No. **3**

Primary Registration District No. **3028**

Registrar's No. **120**

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

1. PLACE OF DEATH:
 (a) County Jasper
 (b) City or town Carthage
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Chaney Rest Home, 316 Fulton St.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 years
(Specify whether years, months or days)
 In this community 20 years

3. (a) PRINT FULL NAME Maomi J. Allen
3. (b) If veteran, name war ---
3. (c) Social Security No. ---

4. Sex female **5. Color or race** white **6. (a) Single, widowed, married, divorced** widowed
6. (b) Name of husband or wife Wm. H. Allen **6. (c) Age of husband or wife if alive** --- years
7. Birth date of deceased December 14 1886
(Month) (Day) (Year)

8. AGE: Years 59 Months 6 Days 14 If less than one day --- hr. --- min.

9. Birthplace Crawford County Illinois
(City, town, or county) (State or foreign country)
10. Usual occupation retired housewife

11. Industry or business ---
MOTHER FATHER { **12. Name** Hugh Moore
13. Birthplace Crawford County Illinois
(City, town, or county) (State or foreign country)
14. Maiden name Rosetta Curtis
15. Birthplace unknown Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Raul R. Allen
(b) Address Rt 4, Carthage, Mo.
17. (a) burial **(b) Date thereof** July 1, 1946
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Sterling Cemetery

18. (a) Signature of funeral director Knell Mortuary
(b) Address Carthage, Mo.
19. (a) 6-28-46 **(b) L. B. Clinton M.D.**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jasper **49**
 (c) City or town Carthage **1**
(If outside city or town limits, write "RURAL") **3**
 (d) Street No. 316 Fulton St.
(If rural, give location) **0**
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country ---

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 28
 year 1946 hour 3:30 minute --- **a** M.
21. I hereby certify that I attended the deceased from 1:30 p.m. 6/27/46
---, 19---, to 3:30 p.m. 6/28, 1946
 that I last saw h. C.Y. alive on 6/27, 1946
 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Edema **1 day**
 Due to Congestive Heart failure
 Due to Coroio-vascular Disease
 Other conditions Hemiplegia due to cerebral thrombosis **2 yrs.**
(Include pregnancy within 3 months of death)
PHYSICIAN ---
 Major findings: ---
 Of operations ---
 Of autopsy ---
 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)
 (e) Means of injury ---
23. Signature William J. Fairhead (M. D. or other) **146**
 Address 407 Main Carthage Mo. Date signed 6/28/46

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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.....

Emma R. Knell

Licensed Embalmer No. *391*

P. O. Address. *Carthage*

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.