

FILED DEC 6 1948-4
 Registration District No. 4

Primary Registration District No. 4356

Registrar's No. 34

1. PLACE OF DEATH:

(a) County Oregon

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

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

(d) Length of stay: In hospital or institution _____
 (Specify whether _____)

In this community Lifetime
 years, months or days

 3. (a) PRINT FULL NAME W. F. Allen

 3. (b) If veteran, name war: --
 3. (c) Social Security No. --

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Annie Laurie Allen

6. (c) Age of husband or wife if alive 82 years

7. Birth date of deceased February 1 1863
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	85	8	20	hr. min

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

 10. Usual occupation Retired Judge

11. Industry or business:

12. Name Isaac Allen

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

14. Maiden name Elizabeth Huff

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

 16. (a) Informant Mrs. W. B. Griffin
 (b) Address Thayer, Mo.

 17. (a) Burial (b) Date thereof 10/24/48
 (Burial, cremation, or removal) (Month) (Day) (Year)

 (c) Place: burial or cremation Thayer Cem.

 18. (a) Signature of funeral director Island Carter
 (b) Address Thayer, Mo.

 19. (a) 12-11-48 (b) Mrs. W. C. Johnson
 (Date received local registrar) (Registrar's signature)

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Oregon

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

(d) Street No. _____
 (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

 20. DATE OF DEATH: Month Oct. day 21
 year 1948 hour 10 minute 10 P. M.

 21. I hereby certify that I attended the deceased from 1948 to Oct 21 1948
 that I last saw him alive on _____ 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death:

Due to:

Due to:

Other conditions (include pregnancy within 3 months of death)

 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? _____
 (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 Low Cooper (M. D. or other) M.D.
 Address Thayer, Mo. Date signed 11-2-48

PHYSICIAN

Underline the cause of which death should be charged statistically.

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

X

RECEIVED 12-1-48
District Health Officer No. 5,
District File Number 1248733
12-3-48

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 _____

Deland Carter

Licensed Embalmer No. _____

4516

P. O. Address _____

Hayes, 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.

Registration District No. 254

Primary Registration District No. 4386

Registrar's No. 348

1. PLACE OF DEATH:

(a) County Oregon
 (b) City or town shayer
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community: _____
years, months or days)

3. (a) PRINT FULL NAME W.F. Allen

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Feb 1 (Month) (Day) (Year)

8. AGE: Years 85 Months _____ Days _____ If less than one day
 hr. _____ min. _____

9. Birthplace _____ (City, town, or county) (State or foreign country) Mo

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
 13. Birthplace _____ (City, town, or county) (State or foreign country)

{ 14. Maiden name _____
 15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____
 (b) Address _____

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

(c) Place: burial or cremation _____

13. (a) Signature of funeral director _____

(b) Address _____

19. (a) 12/11/48 (b) mo w c johnson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____

Of autopsy _____

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) (e) Means of injury

Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

64

S-37523