

FILED SEP 12 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26776

BIRTH NO. 41426-49 REG. DIST. NO. 141 PRIMARY REG. DIST. NO. 3025 Registrar's No. 1

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. Institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Oregon</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>West Plains</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Roskronong</u>	
c. LENGTH OF STAY in this place <u>2 hrs</u>		7 <u>3</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Christa Hogan</u>		d. STREET ADDRESS (If rural, give location) <u>R 2 D 1</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Wesley</u> (Middle) <u>W.S.</u> (Last) <u>Allen</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>7-17-1949</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>M</u>	8. DATE OF BIRTH <u>7-17-49</u>	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days Hours Min. <u>2</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>West Plains Mo.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					

13a. FATHER'S NAME <u>W. D. Allen</u>		13b. MOTHER'S MAIDEN NAME <u>Rosa Hogan</u>		14. NAME OF HUSBAND OR WIFE <u>W. D. Allen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>W.D. Allen</u>		17. INFORMANT'S SIGNATURE OR NAME <u>W.D. Allen</u>	
				ADDRESS <u>Roskronong Mo</u>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pneumonia</u>		MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>9 7/10 X</u>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b)			
		DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from July 17, 1949 to July 17, 1949, that I last saw the deceased alive on July 17, 1949 and that death occurred at 2:00 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Beatrice Cook</u> (Deponent title)		23b. ADDRESS <u>West Plains, Mo.</u>		23c. DATE SIGNED <u>28/7/49</u>	
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24a. BURIAL CREMATION, REMOVAL (Specify) <u>B</u>		24b. DATE <u>7-18-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Roskronong, Roskronong Mo</u>	
24d. LOCATION (City, town, or county) (State) <u>West Plains Mo</u>					

DATE REC'D BY LOCAL REG. <u>8-29-49</u>		REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>		379	
FUNERAL DIRECTOR'S SIGNATURE <u>Robertson</u>		ADDRESS <u>West Plains Mo</u>			

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

RECEIVED 9/6/49
District Health Officer No. 5,
District File Number 949589
Date Filed 9/6/49

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 _____
Student Embalmer No. _____
working under my personal supervision.

Signed _____
Student Embalmer _____
Licensed Embalmer No. _____
P. O. Address _____

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.