

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29089**

BIRTH NO. _____ REG. DIST. NO. **297** PRIMARY REG. DIST. NO. **3057** Registrar's No. **62**

1. PLACE OF DEATH a. COUNTY Ray		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Ray	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Richmond		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Richmond	
d. FULL NAME OF HOSPITAL OR INSTITUTION South Thornton Street		d. STREET ADDRESS (If rural, give location) South Thornton Street	

3. NAME OF DECEASED a. (First) HARRY b. (Middle) _____ c. (Last) ALLEN		4. DATE OF DEATH (Month) (Day) (Year) August 9 1952	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH Nov. ? 1927
9. AGE (In years last birthday) 64		IF UNDER 1 YEAR Months 9 Days ?	IF UNDER 2 HRS. Hours ? Mins. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) Richmond Missouri
			12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME John Allen	13b. MOTHER'S MAIDEN NAME Betsey Anderson	14. NAME OF HUSBAND OR WIFE Never married
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes World War I	16. SOCIAL SECURITY NO. 496-09-3089	17. INFORMANT'S SIGNATURE OR NAME Walter Allen, Richmond, Missouri	ADDRESS _____
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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.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Haemorrhage		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	11. 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 checked="" type="checkbox"/> NO <input type="checkbox"/>
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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) _____
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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? _____
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

22a. SIGNATURE John F. Barber, Coroner Richmond Mo	(Degree or title) _____	23b. ADDRESS _____	23c. DATE SIGNED 8-15-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8-19-1952	24c. NAME OF CEMETERY OR CREMATORY Woodland Cemetery	24d. LOCATION (City, town, or county) (State) Richmond Missouri
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DATE REC'D BY LOCAL REG. Aug 26 - 1952	REGISTRAR'S SIGNATURE Malcolm Jackson	25. FUNERAL DIRECTOR'S SIGNATURE Thomas J. Carter	ADDRESS Richmond, Mo
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(Licensed Embalmer's Statement on Reverse Side)

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

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MAY 28 1953

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.

Student
Student Embalmer

Signed Thomas J. Carter

Licensed Embalmer No. 4474

P. O. Address Richmond, Va

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.