

FILED MAR 30 1953

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **9388**

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>294</u>	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).			
a. COUNTY <u>Greene</u>		b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>		a. STATE <u>Missouri</u>		b. COUNTY <u>Hickory</u>	
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>		c. LENGTH OF STAY (in this place) <u>5 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Wheatland</u>		<u>1430</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Burge Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>no street address</u>			
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH			5. SEX	
a. (First) <u>VIRGIL</u>	b. (Middle) <u>ROBERT</u>	c. (Last) <u>ALLEN</u>	Month <u>March</u>	Day <u>20</u>	Year <u>1953</u>	Male <u>0</u>	Female <u>0</u>
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 1, 1914</u>		9. AGE (In years last birthday) <u>38</u>	IF UNDER 1 YEAR Months _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operator Service Sta</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retail Gas &amp; Oil</u>		11. BIRTHPLACE (State or foreign country) <u>Wheatland, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Clyde Allen</u>		13b. MOTHER'S MAIDEN NAME <u>Wave Coffman</u>		14. NAME OF HUSBAND OR WIFE <u>Faye Allen</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Faye Allen, Wheatland, Missouri</u>			
18. CAUSE OF DEATH		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
Enter only one cause per line for (a), (b), and (c)		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Lymphosarcoma</u>				<u>9 months</u>	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		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"/>	
		<u>2001</u>					
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)			
				<u>Wheatland, Missouri</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)		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 <u>12-12</u> , 19 <u>52</u> , to <u>3-20-53</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>3-20</u> , 19 <u>53</u> , and that death occurred at <u>1:45 P. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>James E. Marshall, M.D.</u>				23b. ADDRESS <u>Professional Building</u>		23c. DATE SIGNED <u>3-21-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>March 20, 1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Unknown</u>		24d. LOCATION (City, town, or county) (State) <u>Wheatland, Missouri</u>		
DATE REC'D BY LOCAL REG. <u>3-26-53</u>		REGISTRAR'S SIGNATURE <u>Edith Williamson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Alma Schmeyer</u>		ADDRESS <u>Springfield, Mo</u>	

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

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*Dr. [unclear]*

**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 James W. Wair

Licensed Embalmer No. 4650

P. O. Address Springfield, 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.