

FILED SEP 23 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31117**

BIRTH NO. _____ REG. DIST. NO. **170** PRIMARY REG. DIST. NO. **3635** Registrar's No. **100**

1. PLACE OF DEATH a. COUNTY Laclede		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Laclede	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Conway-Union TP		c. LENGTH OF STAY (in this place) 50 Years	c. CITY OR TOWN Conway RR
d. FULL NAME OF HOSPITAL OR INSTITUTION C-C Road		STREET ADDRESS (If rural, give location) C-C Road 0220	

3. NAME OF DECEASED (Type or Print) a. (First) Minnie b. (Middle) Lee c. (Last) Allen			4. DATE OF DEATH (Month) (Day) (Year) Sept. 5, 1954
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 9, 1879	9. AGE (In years, months, days, hours, minutes) 74
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10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Domestic	11. BIRTHPLACE (City and State or Foreign Country) Laclede County Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Kallop More	13b. MOTHER'S MAIDEN NAME Elmira Caffey	14. NAME OF HUSBAND OR WIFE Willard Allen
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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) No.	16. SOCIAL SECURITY NO. None.	17. INFORMANT'S SIGNATURE OR NAME Mr. Willard Allen	ADDRESS Conway, Mo.
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 3 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Medullary Failure		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Thrombotic Encephalomalacia DUE TO (c) Arterio sclerosis.		
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"/>
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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) 332 X
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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 8-2-1954, to 9-5-1954, that I last saw the deceased alive on 9-5-1954, and that death occurred at 11:45 P.M., from the causes and on the date stated above.

23a. SIGNATURE <i>[Signature]</i>	(Degree or title) Dr. J. Marshall, M.D.	23b. ADDRESS Webster County Missouri	23c. DATE SIGNED 9/9/54
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24a. BURIAL, CREMATION, REMOVAL	24b. DATE 9-8-54	24c. NAME OF CEMETERY OR CREMATORY Goodsprings Cemetery	24d. LOCATION (City, town, or county) (State) Webster County Missouri
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DATE REC'D BY LOCAL REG. 9-11-1954	REGISTRAR'S SIGNATURE <i>[Signature]</i>	424	25. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>	ADDRESS Lebanon, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Received SEP 19 1954
Laclede County Health Unit
File No. 9-54-148
Date Filed SEP 22 1954

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

Signature of Student Embalmer

Signed

Stanley R. Palm

Licensed Embalmer No. 4810

P. O. Address Lebanon

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.