

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

**58-031773**  
STATE FILE NUMBER 1004

FILED SEP 29 1958

Registration District No. **42** Primary Registration District No. **1000** Registrar's No. **1004**

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR Parkview at Sunnyslope INSTITUTION 5225 So. 11th		Length of stay in lb 10 Yrs		d. STREET ADDRESS (If outside, give location) 1224 So. 6th		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last LEO ALLEN				4. DATE OF DEATH Month Day Year Sept. 20, 1958			
5. SEX Male <input type="checkbox"/> Female <input checked="" type="checkbox"/>	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 13, 1890		9. AGE (In years) 68	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. (3) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (City and state or country) Decatur Co., Iowa		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME George Allen			13b. MOTHER'S MAIDEN NAME Minnie Merritt			14. NAME OF HUSBAND OR WIFE Anna	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, never unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 491-10-5644		17. INFORMANT Address Emmett Loe St. Joseph, Mo.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>arteriosclerotic heart disease</u>		DUE TO (c) <u>4200</u>		not sure	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)				
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>Sept 18-58</u> to <u>Sept 20-58</u> and last saw her alive on <u>Sept 19-58</u> Death occurred at <u>10:05</u> A m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Collis Roundy M.D.</u>				22b. ADDRESS <u>Propa Wood Bldg</u>		22c. DATE SIGNED <u>9-20-58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Sept. 22, 58	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) St. Joseph, Mo.		(State)
24. FUNERAL DIRECTOR ADDRESS <u>Norman W. Sidenfaden St. Joseph, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>Sept 21, 1958</u>		26. REGISTRAR'S SIGNATURE <u>Wm. Clark Lovell</u>		

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
Dr. Collis Roundy

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 *Robert H. Gaylor* .....  
Licensed Embalmer No. 3308 .....  
P. O. Address St. Joseph, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.