

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-014037

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 845

FILED MAR 18 1963

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>ILLINOIS</b> b. COUNTY <b>CLINTON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>JEFFERSON BARRACKS MISSOURI</b>		Length of stay in 1b <b>8 DAYS</b>	c. CITY OR TOWN <b>CARLYLE</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>611 FRANKLIN STREET</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>ARCH J. ALLEN</b>			4. DATE OF DEATH Month Day Year <b>MARCH 10 1963</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>12-31-88</b>
9. AGE (last birthday) <b>74</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GROCERY STORE</b>	11. BIRTHPLACE (City and state or country) <b>HUMBOLT, KANSAS</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>WILLIAM ALLEN</b>	
13b. MOTHER'S MAIDEN NAME <b>GRACE ROGERS</b>		14. NAME OF HUSBAND OR WIFE <b>DIVORCED</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <b>YES WW-1</b>		16. SOCIAL SECURITY NO. <b>[REDACTED]</b>	
17. INFORMANT <b>MARY SHARPE (SISTER)</b>		Address <b>CARLYLE, ILLINOIS</b>	
18. CAUSE OF DEATH (Enter only one cause per part) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC FAILURE</b> DUE TO (b) <b>PNEUMONIA</b> DUE TO (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>UNK</b> <b>UNK</b> <b>UNK</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>PULMONARY TUBERCULOSIS</b>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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 a.m. p.m. Month, Day, Year	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. <b>V.A.</b> attended the deceased from <b>3-2-63</b> to <b>3-10-63</b> Death occurred at <b>10:30 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>George B. Neukom M.D.</i> <b>GEORGE B. NEUKOM, M.D.</b>		22b. ADDRESS <b>VET ADM HOSP, JEFF BRKS, 25 MO</b>	22c. DATE SIGNED <b>3-10-63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>3/12/63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Carlyle City Cemetery</b>	23d. LOCATION (City, town, or county) <b>Carlyle Illinois</b>
24. FUNERAL DIRECTOR <b>Zieren-Day Funeral Home Carlyle Ill.</b>		25. DATE RECD. BY LOCAL REG. <b>3-10-63</b>	26. REGISTRAR'S SIGNATURE <i>John M. Murphy</i>

USE BLACK INK OR TYPEWRITER RIBBON

**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 James L. Crosson

Licensed Embalmer No. 5168

P. O. Address Millstadt, Ill.

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.