

FILED AUG 15 1947

Registration District No. 3

Primary Registration District No. 4082

1. PLACE OF DEATH:

(a) County Carroll
(b) City or town RURAL - Van Horn Twp.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
R.R. # 4 John Bogard.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community all his life (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Carroll 17
(c) City or town RURAL
(If outside city or town limits, write "RURAL")
(d) Street No. Bogard mo R.R. # 4
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME William Jacob Allen

3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M /
6. (b) Name of husband or wife Maggie Allen 6. (c) Age of husband or wife if alive 72 years
7. Birth date of deceased Oct - 29 - 1869
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
77 8 20 _____ hr. _____ min.

9. Birthplace Wakenda Mo
(City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business _____

MOTHER, FATHER { 12. Name Reuben Allen
13. Birthplace Don't know Ky
(City, town, or county) (State or foreign country)
14. Maiden name Elizabeth Sparks
15. Birthplace Don't know Ky
(City, town, or county) (State or foreign country)

16. (a) Informant Ray Allen
(b) Address Bogard
17. (a) BURIAL (b) Date thereof 7-21-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation VAN HORN

18. (a) Signature of funeral director E.A. Dickerson
(b) Address Bogard, Mo.
19. (a) 7-21-47 (b) Emmie Street
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 19 year 1947 hour 7 minute 45 A.M.

21. I hereby certify that I attended the deceased from July 18 to July 19 1947
that I last saw him alive on July 18 1947
and that death occurred on the date and hour stated above.

Immediate cause of death cardiac failure 1/2 hr
Due to myo cardiac degeneration 4 yrs
Due to _____

Other conditions _____
(include pregnancy within 3 months of death)

Major findings: Of operations 93 D
Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? no

While at work _____ (Specify type of place) (b) Major injury _____
23. Signature R. Hamilton (M. D. or other) MAJ
Address Carrollton, Mo. Date signed July 19 1947

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

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed 8-14-47

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

....., Registered Apprentice No.
working under my personal supervision.

Signed E. A. Dickerson

Licensed Embalmer No. 2134

P. O. Address Boyard, 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.