

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

33891

1927
145
PLACE OF DEATH
County Jasper Registration District No. 417
Township West City Primary Registration District No. 3021
City Webb City (No.) St. Ward)

File No.
Registered No. 143

2. FULL NAME Mrs. Nancy K. Allen
(a) Residence No. 2 Madison St. Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Widowed

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 14 11

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
5 1/2 | 10 | X

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Mt. Vernon Ill.
(STATE OR COUNTRY)

10. NAME OF FATHER Tom Watson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ill.
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Sarah Wallace

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ill.
(STATE OR COUNTRY)

14. INFORMANT Geo. W. Moore
(Address) Webb City Mo.

15. FILED Nov. 15 1927 R. M. Hornum
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 14 1927

17. I HEREBY CERTIFY That I attended deceased from 11/6 1927 to 11-14 1927 that I last saw h. alive on 11/14 1927, and that death occurred, on the date stated above, at 11 P

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of Left Ovary & Sigmoid
49 1/2 (duration) 8 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 4 1/2 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH..... No

DID AN OPERATION PRECEDE DEATH? No DATE OF.....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Ed Dambault, M. D.
1/13 1927 (Address) Webb City Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Miami Okla. DATE OF BURIAL 11/16 1927

20. UNDERTAKER Webb City Und. Co. ADDRESS Webb City

K. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

WRITE IN INK, WITH CARE

N. B.—Every form of information should be carefully supplied.
USE OF DEATH in plain terms, so that it may be understood.

ARMAMENT RECORD
FACILITY. PHYSICIANS should state
OCCUPATION is very important.

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Jasper Registration District No. 417 File No. _____
 Township _____ Primary Registration District No. 3021 Registered No. 143
 City Webb City (No. _____) St. _____ Ward _____

2. FULL NAME Nancy F. Allen

(a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) W

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 14 1871

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
56 | 10 | 0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____

(STATE OR COUNTRY) _____

10. NAME OF FATHER _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____

(STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____

(STATE OR COUNTRY) _____

14.

INFORMANT _____
 (Address) _____

15.

FILED 1-12-28 R. M. Stormont
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 14 1927

17. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____, that I last saw h. _____ since on _____, 19____, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH? _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.

, 19____ (Address) _____

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____

DATE OF BURIAL _____

20. UNDERTAKER _____

ADDRESS _____

UNFADING INK--THIS IS A P

N. P. _____ carefully applied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH must be properly classified. Exact statement of CAUSE OF DEATH must be properly classified.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-33891