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

DEC 24 1927

Do not use this space.
36698

File No. 166
Registered No.

1. PLACE OF DEATH
County Howell
Township
City West Plains (No. , St. , Ward)
Registration District No. 3824
Primary Registration District No. 4827

2. FULL NAME Mary Ann 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
F	White	Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3/17/1854

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
73	3	25	

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) Missouri

PARENTS
10. NAME OF FATHER George W. Galloway
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Tennessee
12. MAIDEN NAME OF MOTHER Rhoda Stinecipher
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Tennessee

14. INFORMANT Roy Allen
(Address) Geary Oklahoma

15. FILED 12-12-27 O. A. Heinrich
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 12th, 1927

17. I HEREBY CERTIFY, That I attended deceased from Dec. 10th, 1927, to Dec. 12th, 1927, that I last saw her alive on Dec. 12th, 1927, and that death occurred, on the date stated above, at 6:20 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Haemorrhage, gastric.
(duration) yrs. 2 mos. ds.
CONTRIBUTORY (SECONDARY) Gastric ulcer. Lung disease undtermined. (duration) Undetermined. yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? Oklahoma.
DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY? No.
WHAT TEST CONFIRMED DIAGNOSIS? Clinical.
(Signed) A. H. Thorn Lungh By [illegible] M. D
12/12, 1927 (Address) West Plains, 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	DATE OF BURIAL
Geary Okla.	V 19
20. UNDERTAKER George Q. Stapp	ADDRESS West Plains Mo

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

REGISTRAR SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW. Every item of information should be carefully supplied. AGE should be stated EXACTLY. Cause of DEATH must be stated in plain terms, so that it may be properly classified. Exact statement of OCC

1. PLACE OF DEATH
County Howell — Registration District No. 384 — File No. 116
Township — Primary Registration District No. 4227 — Registered No.
City West Plains (No. ..... St. ..... Ward)

2. FULL NAME Mary Ann 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
F	W	W

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

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.

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)

PARENTS
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 12-17-1927 O. A. Heinrich
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 12 1927

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
.....
.....(duration).....yrs. .....mos.....ds.
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
	12-18 1927
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

S-36692